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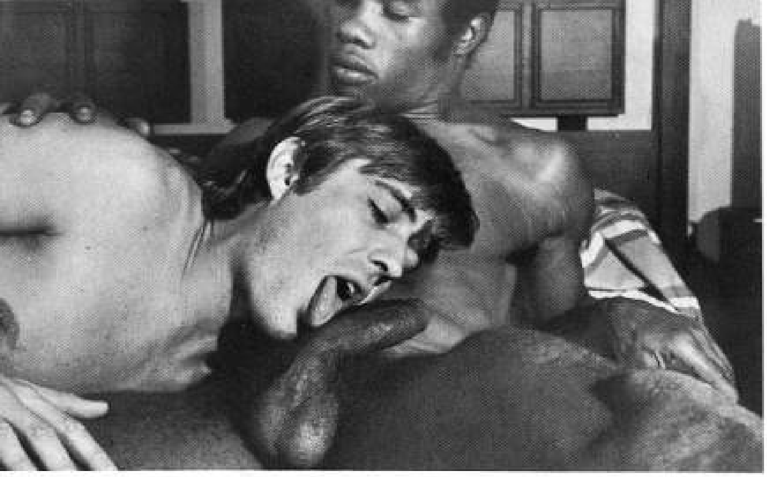
Contemporary
Gay Sex Techniques

VOLUME 1.

An Informative
SEX MANUAL



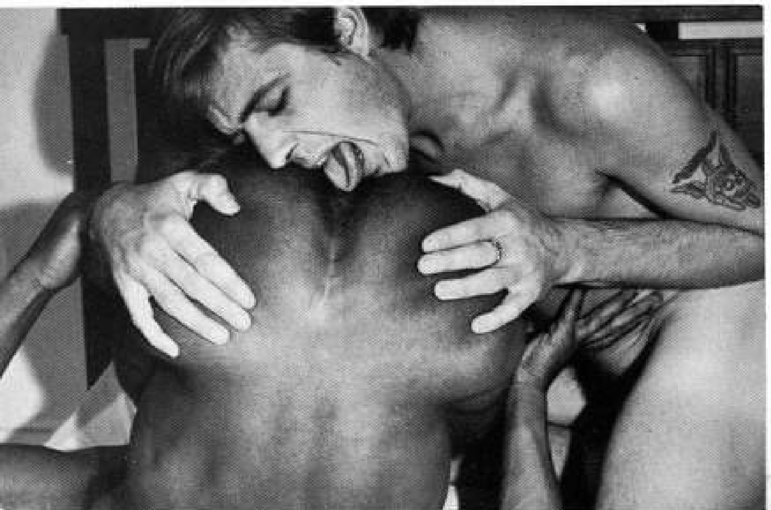
THE MALE HOMOSEXUAL

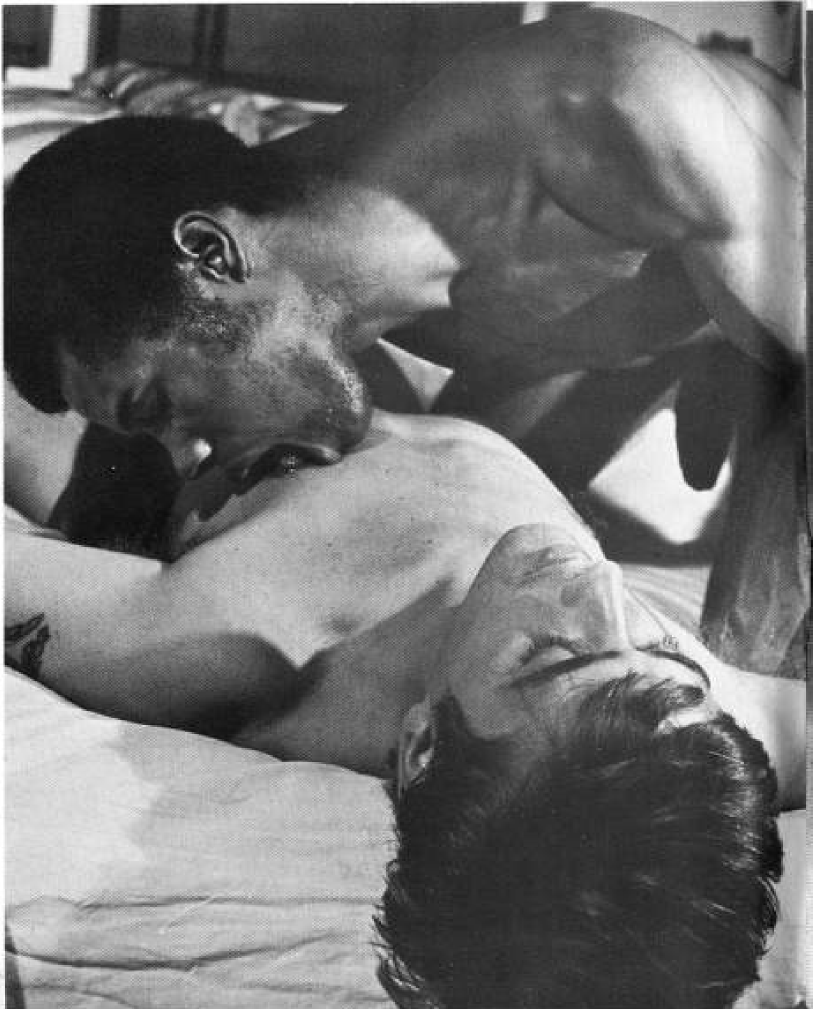
INTRODUCTION

Despite the fact that today's society is more aware, gays still find themselves the focal point of a highly controversial dilemma. This role is quite appropriate because no other area of human behavior is so emotionally charged as homosexuality. It not only affects the homosexual but the society in which it exists.

It has only been with the last fifty years that anything approaching the dispassionate objectivity of scientific research has been brought to bear on this field. Previous writers dealing with sexual behavior have been intuitive or empirical at best. However, since the pioneering efforts of Dr. Alfred C. Kinsey, we have had much more definitive investigation. At long last, a wealth of research is slowly beginning to shed important light on the very nature of homosexuality.

In the past the homosexual has lived in a minority group. He was never sure whether his condition was a



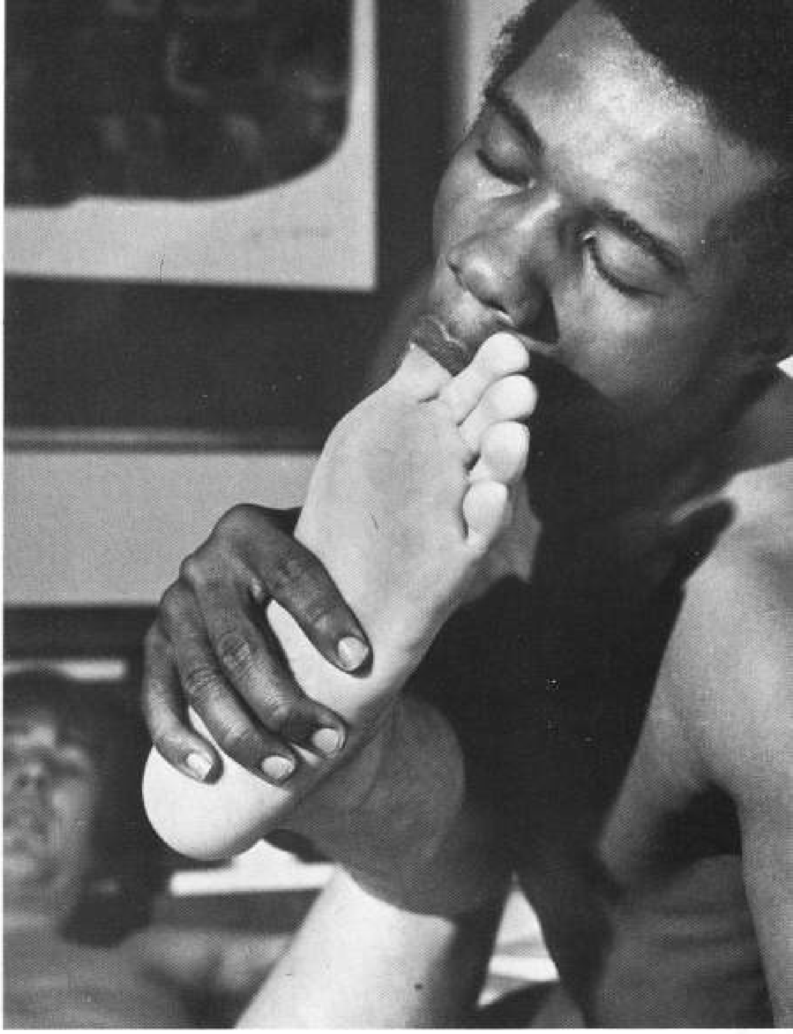


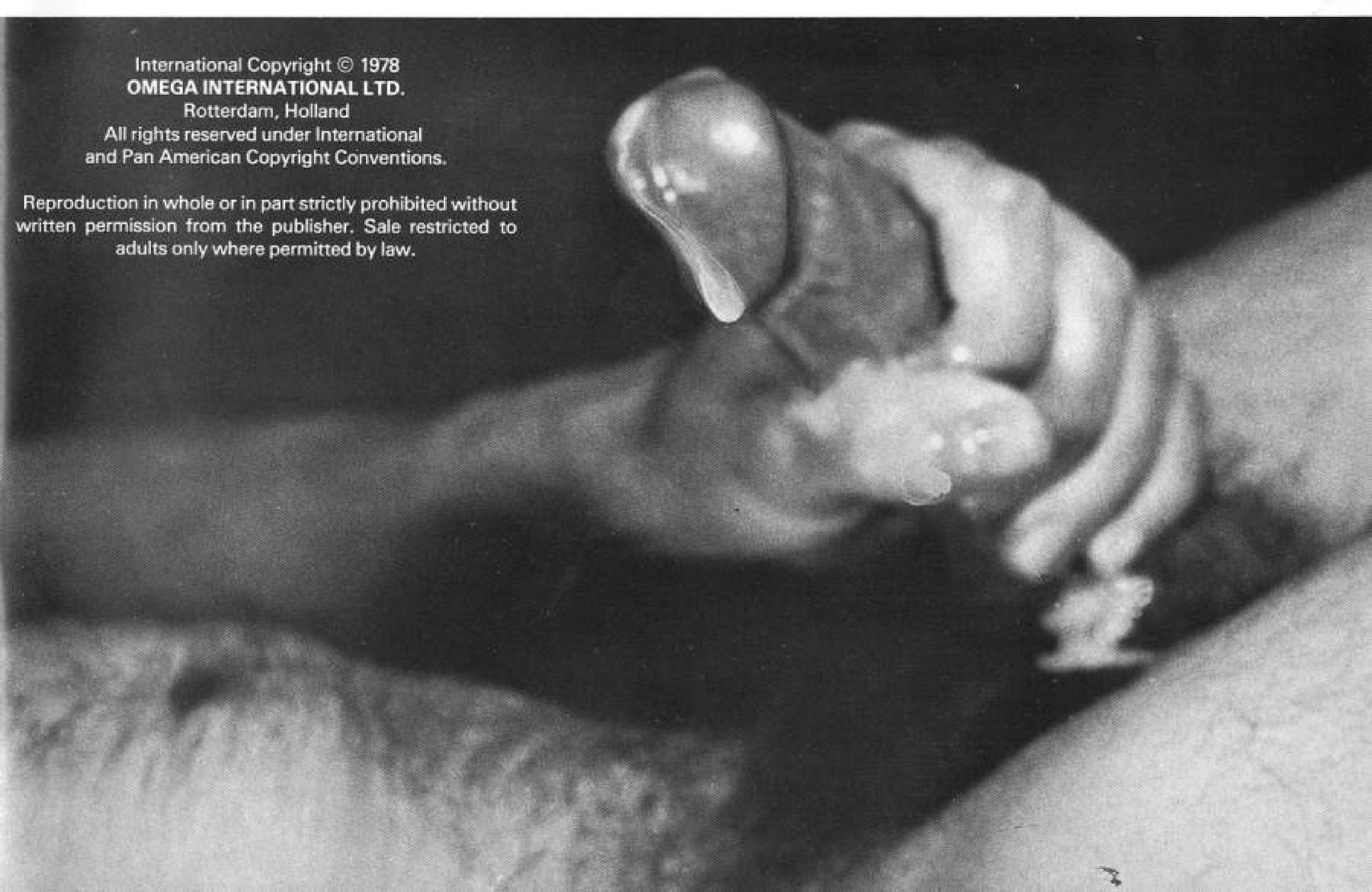
curse or a blessing, whether he had been shackled with a malign destiny, or whether he was a member of some talented or intellectual elite who could either flaunt or hide his uniqueness. Oscar Wilde referred to homosexuality as a "monstrous martyrdom."

For many centuries the sexual heretic has shared in common with the religious heretic a common ground of historic suffering that has finally elevated the problem to a cause. The public attitude on this complex subject is apparently yielding to enlightenment. But for the homosexual acceptance is not yet a reality.

The study of homosexuality is a broad enterprise. It covers an infinite variety of intrasexual relationships and mutations that, critics notwithstanding, closely parallel those within the heterosexual community.

Archaic laws have spelled out what is considered to be acceptable sexual practice. We find ourselves in an Anglo-Saxon, Judeo-Christian culture, which is at once restricting and hypocritical. This has produced a puritanical attitude toward all matters of sex. Established social institutions reflect the basic premise that





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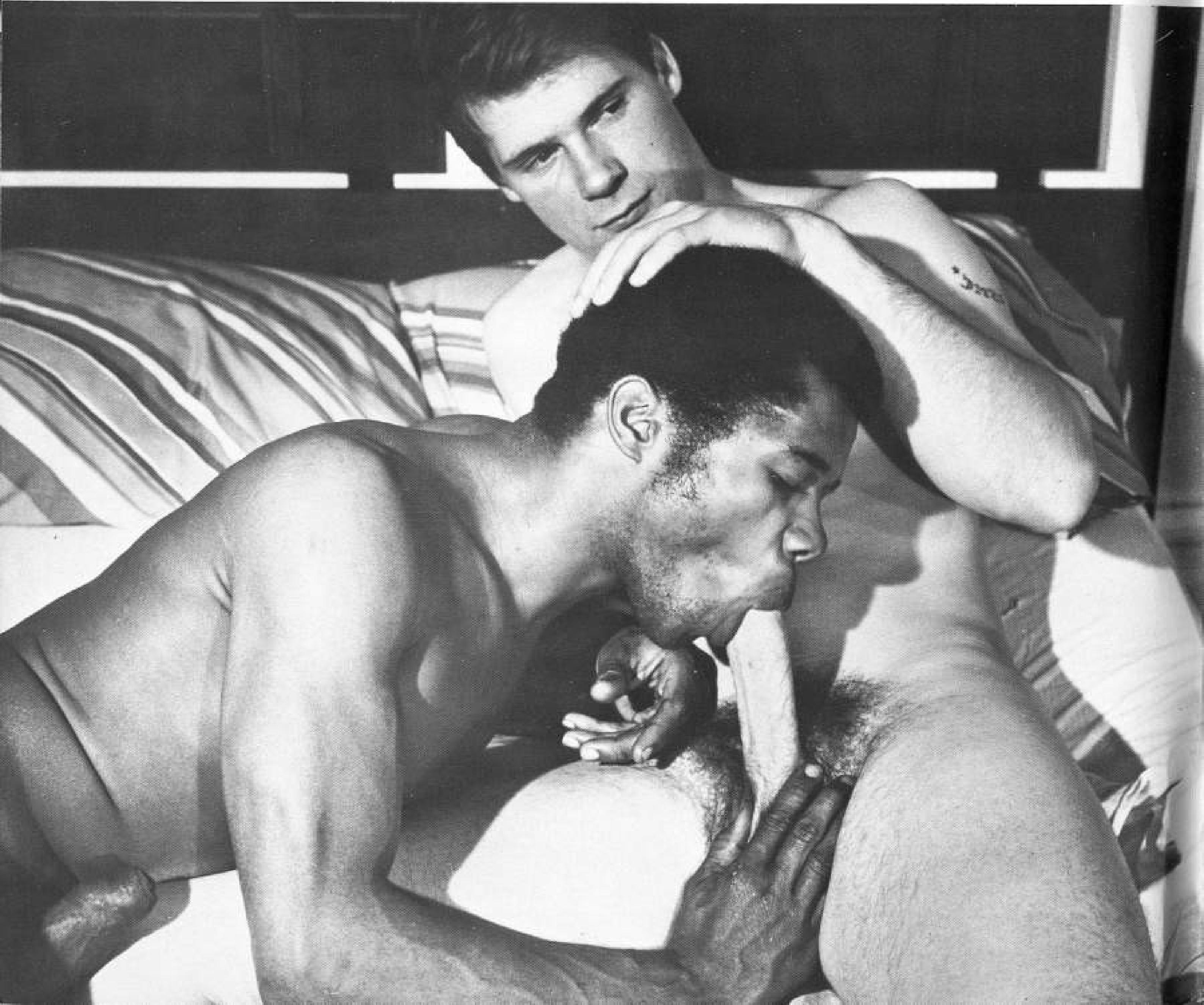
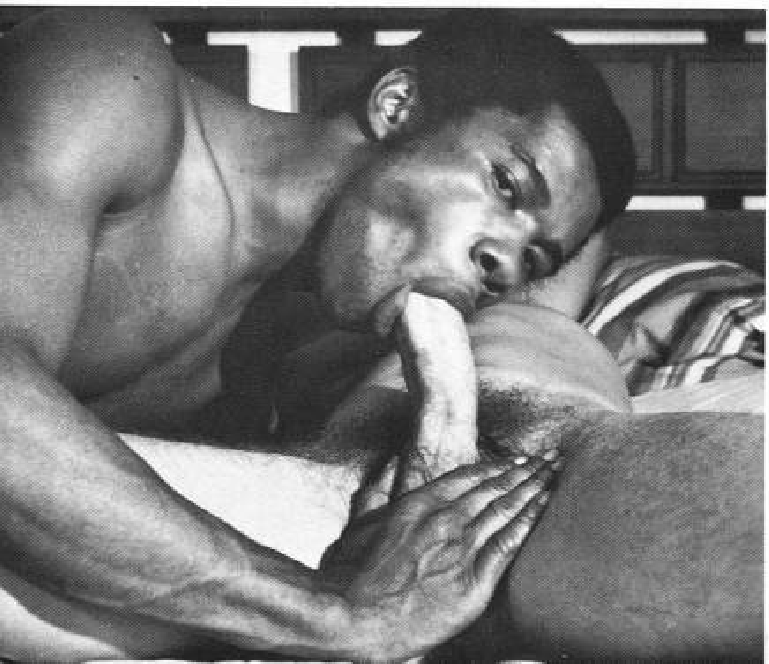


the marriage bed is for procreation; recreation and pleasure are really frowned upon. Many feel that authorities have been unreasonably overzealous in carrying out a misguided mandate to structure society along such lines of behavior. Such repressive methods have failed before, most notably in the attempt to legislate morals regarding the use of alcoholic beverages.

The irony of this hypocrisy that controls sexual practices is that sexual heresy is not exclusive of the homosexual minority. Investigations reveal that variations on sexual practice occur with much greater frequency in the heterosexual situation for the simple reason that the opportunity to do so is much more readily obtainable. The heterosexual marriage offers privacy and community acceptance for most types of sexual practices. This may be one of the factors that is establishing a more reasoned attitude toward the homosexual. But if these variations or deviations are openly revealed to public scrutiny, the heterosexual partners would be as liable to scornful punishment as is the homosexual. The intensity of this double standard has pricked the public conscience sufficiently to effect a change in mood regarding all matters sexual. Some changes in laws and some court decisions have pointed the way to continuing sexual practices.



GAY SEX TECHNIQUES:

ANATOMICAL SEXUAL RESPONSE

In order to understand the nature of specific sexual acts performed by homosexuals it is advisable to briefly discuss the physiology of the male sexual organs and the male's physical reaction to elevated levels of sexual tension. This includes extragenital reaction as well as reactions of the primary and secondary organs of reproduction. Sexual tension develops throughout the body.

Consider first the erogenous zones of "spots of eroticism" of the male body. Actually the entire male body is an area of sexual excitation when touched by the hands, lips or genitals. Just the feeling of a partner's hands moving softly, tenderly, gently anywhere on the body will create a sensation of comfort and enjoyment in most males. There are, however, specific areas which have the power to produce definite thrills of sexual excitement. These erogenous zones include the following: the ears, cheeks, mouth, neck, shoulders, breast, nipples, waist, stomach, hips, thighs, legs, toes, and in particular the glans, scrotum, perineum and anus.

There is still a great deal of anger from the majority directed toward the apartness of the homosexual minority. Homosexuality is still regarded as the misfortune of a peculiar people. But today sociologists, historians and behaviorists are turning the lights of knowledge upon the problem of the homosexual in a heterosexually oriented world. We shall illuminate the process; we shall provide a bridge between society and that elusive apartness of the homosexual minority.

As Kinsey explained in his Sexual Behavior in the Human Male: "If it is understood that sexual stimulation and response may involve and usually do involve a major portion of the nervous system and not merely that portion of the system which is located in or connected with the genitalia, it will be seen that any area of the body which is abundantly supplied with end organs of touch may become a center for erotic arousal and response. Such 'erogenous zones' are most prominent on the lips, in the interior of the mouth and on the tongue, on the breasts of certain individuals, on certain portions of the genitalia and in the anal area.

There is, however, no part of the surface of the human body which may not be a source of sexual stimulation and response, for there is no appreciable area of the skin which is without end organs of touch. For different individuals, the erotic responsiveness of different areas may vary depending in part on the psychologic conditioning of the individual as a result of his previous experience, but probably as often depending upon differences in the innervation of the same area in different individuals."

The basic pattern of physiologic response involves, first, both superficial and deep vasocongestion, and second, both generalized and specific myotonia. These are in addition to certain other reactions which ought to be touched upon.

We may best follow the example of Masters and Johnson, who found that ". . .a concise picture of physiologic reaction to stimuli may be presented by dividing the human male's. . .cycles of sexual response into four separate phases. Progressively, the four phases are: (1) the excitement phase; (2) the plateau phase; (3) the orgasmic phase; and (4) the resolution phase."

Masters and Johnson found that there was no consistent anatomic response of the male breast to sexual stimulation. They stress, however, that nipple erection and tumescense do occur in some males; where such erection occurs, they ordinarily develop late in the excitement stage and remain through the termination of the sexual cycle, sometimes continuing as long as an hour after ejaculation.

Koble and Warren found that a man's nipples, not unlike a woman's, are sensitive to sexual stimulation; they too stiffen, and though their reaction is not as acute as those of a woman, there is sufficient response in them to assist in attaining the preorgasmic stage.

Kinsey discovered that, in general, heterosexual males have had little experience in testing the erotic potential of their breasts, because female partners rarely think to manipulate the male's nipples. He went on to say, "Among males with extensive homosexual histories, however, breast manipulation is fairly frequent and it is commonly known in such groups that many males have very highly sensitive breasts. The data from such cases indicate that there may be as many males as females who are sensitive to breast stimulation." Usually after the plateau phase is well established, or sometimes late in the excitement phase, the male may experience a maculopapular sex flush, a reddening which, when fully developed, is similar to a measles rash. This begins ordinarily at the epigastrium, spreading over the chest wall and, progressively, the neck, face and forehead, occasional-

ly appearing on shoulders, forearms and thighs. Appearance of a sex flush is evidence of high levels of sexual tension.

Late in the excitement phase and through the orgasmic phase, myotonia occurs, muscles contracting with regularity or in involuntary spasms, dependent upon position and sexual activity; e.g., carpopedal spasm is more frequent during masturbatory episodes than during intercourse. At the time of orgasm, the human male may exhibit contortions of the body, especially of the feet, that would be impossible for him at any other time.

During this same period, the external rectal sphincter may contract irregularly, particularly after direct stimulation. There is an involuntary contraction during ejaculation as well. These ejaculatory contractions customarily recur with 0.8 second intercontractile intervals, simultaneous with the contracting of the periurethral musculature, but recurring no more than two to four times.

During the late plateau and the orgasmic phase, hyperventilation normally occurs, and may be an indicator of the degree of sexual tension. During orgasm a respiratory rate of 40 per minute is not unusual.

The heart rate of the male increases with his sexual tension reaching 110 to 180+ beats per minute during orgasm. There is an elevation in systolic blood pressure as well, ranging from 40 to 100 mm. HG., diastolic pressure elevations range from 20 to 50 mm. HG.

As the race toward orgasm accelerates there is a marked increase in the pulse rate, blood pressure and peripheral circulation, as well as the flow of blood into distensible organs such as the eyes, lips, ears, lobes, nipples, penis, etc There is an increase in

nervous tension and a loss of sensory perception—an individual at the point of orgasm may be nearly insensitive to sight and sound. A further reaction is an involuntary sweating which many males evidence immediately after ejaculation.

It should be stressed that sexual arousal is not exclusively a physiological matter confined to these certain areas and phenomena. Erotic arousal is a material phenomenon which involves an extended series of physical, psychologic, and physiologic changes. Tactile stimulation is the chief form of arousal in the higher mammals, including man, but the human male becomes conditioned by experience, the result of which is that psychological stimulation becomes major, perhaps the chief source of stimulation. There are a few rare individuals who come to climax through psychologic stimulation, particularly in the older individual.

There are numerous volumes which provide detailed descriptions of the anatomy of the penis. For purposes of orientation we shall include herein a very brief summary of this important organ.

The penis is made up of three cylindrical bodies of erectile tissue. Two of these, the corpra cavernosa penis, are parallel to one another and over the third, the corpus spongiosum, the latter containing the uretha as well as erectile tissue. At its base the corpus spongiosum expands into the urethal bulb and at its tip it forms the glans penis. Each of these corpora is individually surrounded by a fibrous coat, the tunica albuginea, and all three are enclosed in dense fascial capsules.

At the base of the penis the corpora cavernosa penis separate and form the crura, which attach to the pubic arch. The crura are sheathed by skeletal muscle, the ischiocavernosus. The corpus spongiosum

is encapsulated by the bulbospongiousus muscle.

The corpora cavernosa and the corpus spongiosum receive arterial blood from branches of the internal pudendal arteries, i.e., the dorsal arteries of the penis, located near the dorsal surface of the penis, the cavernous arteries running through each corpus cavernosum penis, and two bulbourethral arteries running through the corpus spongiosum slightly ventral to the uretha. The helicine arteries, terminal branches of the aforementioned principal arteries, end in small capillaries that open into the cavernous spaces.

The venous return is by the superficial dorsal vein which drains the corpous spongiosum, the glans and the urethral bulb, and by the deep dorsal vein, draining the corpora cavernosa penis.

The cavities of the corpora cavernosa contain many compartments separated by threads of fibrous tissue called trabeculae. These compartments are dispersed with arterioles whose intima are thought to contain ridges which contract to constrict the blood flow entering the cavernous sinuses. When the arteries dilate, the flow of blood into the penis is increased and the sinuses are filled. The penis veins are thought to utilize valves to slow the return of blood from the penis.

It is important to note that the act of erection is at best imperfectly understood. Masters and Johnson state that "a center for reflex erection is believed to exist in the sacral portion of the spinal cord." Stimulation of erection would certainly seem to come from higher cortical centers.

Erotic function in the male genitalia has been concentrated in the external pelvic anatomy. The penis itself provides the most dramatic evidence of arousal. The scrotum and testes are particularly sensitive as well, as is the rectum. The scrotum, in a sexually unstimulated state, ordinarily hangs in multiple folds or creases and moves freely. Both scrotum

and testes respond to sexual stimulation in stages that relate to the four phases of the cycles of sexual response. The prostate, seminal vesicles, vas deferens and other organs are less sensitive.

These structures demonstrate vasocongestion and elevated muscle tension when sexual stimulation occurs. It should be pointed out, however, that vasocongestion and elevated muscle tension do not in themselves evidence sexual tension. Ordinarily, erection and detumescence of the penis reflects rising or falling sexual tension, but there are other factors that may be involved, e.g., the penile erection often evidenced upon awakening from sleep. Likewise involution of the penis, even hyperinvolution, may occur under varied circumstances, such as exposure to cold, especially to cold water; severe physical strain; advanced age; castration; impotence; unsuccessful sexual attempts, etc.

The initial and most apparent physiologic response of the human male to sexual stimulation is penile erection, regardless of whether the stimulation is physical or mental. The erection occurs in the first, or excitement phase; this phase may last briefly or for several minutes after erection has been attained. Penile erection may be maintained for extended periods; it may be partially lost and regained, depending upon stimulation. Penile erection may be adversely affected by nonsexual stimuli, even though direct stimulation continues.

Despite direct stimulation, erection may be partially or totally lost as a result of sudden loud noises, conversation on nonsexual subjects, abrupt changes in lighting, temperature, etc. During this phase, the uretha undergoes a two or threefold increase in diameter, the meatus becomes slightly patulous, there is notable tensing and thickening of the scrotal integument and the scrotal pattern of multiple folding and free movement is rapidly lost.

Constriction produces a decrease in the internal diameter of the scrotal sac and there is a restriction of free movement. The testes are elevated toward the perineum; additionally the testes change their axis of suspension. When the testis is completely elevated, the posterior testicular wall ultimately comes in direct contact with the male perineum.

In the plateau phase, though the penis has seemed to have achieved full erection before, it now undergoes a minor increase in diameter, particularly at the corona glandis. There may occur an emission from the uretha meatus of two or three drops of mucoid substance. This is thought to secrete from the Cowper's glands, but there is no general agreement on this or on the purpose of the secretion. There is an increase in testicular size. Late in this stage there may be a color change as well, a deepening of the mottled, reddish purple color of venous stasis.

The third stage, the orgasmic phase, involves the ejaculatory action which results from regular recurring contractions of the sphincter urethae, bulbospongiosus, ischiocavernosus, and transverse superficial and deep perineal muscles. The entire length of the penile uretha is involved, the contractons forcing the seminal fluid through the urethal meatus. The first three or four major expulsive contractions occur at intervals of 0.8 seconds; subsequent contractions are rapidly reduced in frequency and force. The orgasm of the male is essentially the same regardless of the means by which it has been brought about.

There are myths surrounding the orgasm. It has been suggested in the past that orgasm in some way deletes physical strength or is detrimental to physical

condition, but there is no evidence to support this concept.

In the male a sensation of ejaculatory inevitability occurs immediately prior to the first stages of the ejaculatory experience. There is an interval of a few seconds during which the male is aware of the approach of ejaculation but can no longer delay or control the process. Once begun the orgasm will continue to its end. At the time of the anticipatory experience, seminal plasma is collecting in the prostatic uretha.

As the propulsion of seminal fluid content from uretha to the urethal meatus begins, the male passes through two stages. First the sphincter urethrae contract regularly, creating a contractile sensation. Second, a specific awareness of fluid volume occurs as the seminal plasma is expelled through the penile urethra. The level of pleasure response is usually

highest with the first, most powerful explosive contractions. The response also seems more pleasurable as the seminal fluid volume increases (as after a period of continence, when more fluid is expelled and the pleasure is customarily greater than with second and third orgasm during a comparatively brief period).

On the basis of several thousand case histories, Kinsey cited six basic orgasm types, while stressing that there are countless gradations between each type. They are as follows:

(1) Primarily genital reaction; little if any body tension in evidence; little if any build up to the orgasm, which is reached suddenly; penis becomes more rigid at onset of orgasm, and there may be some mild penile throbs, or the throbs may be solely urethral; the semen seeps from the urethra rather than being forcefully ejaculated; minor aftereffects subsequent to climax.

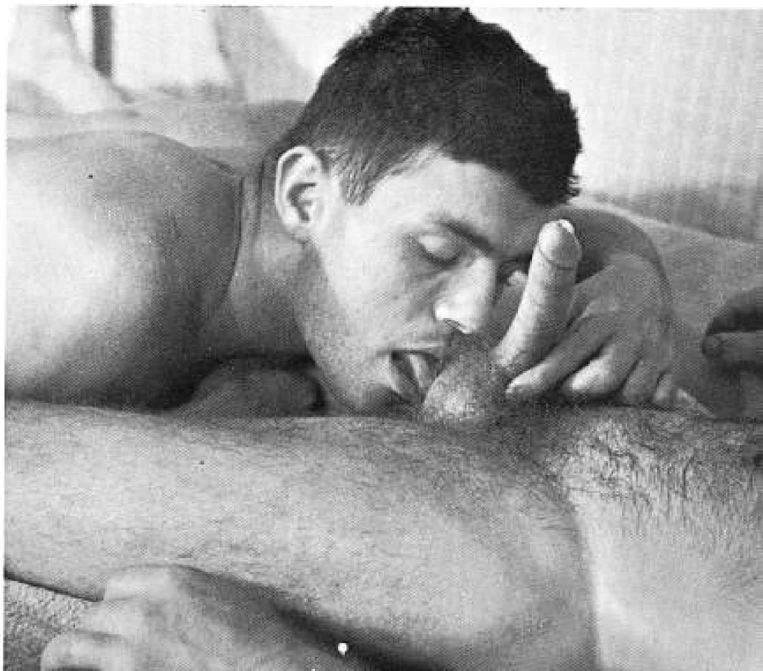
(2) More body tension than above, often with tension or twitching of one or both legs, sometimes the mouth, arms or other body parts. Build up to climax is gradual, involving rigidity of the entire body and some penile throbbing; orgasm occurs with a few spasms but little aftereffect. This was noted as the most common type of orgasm.

(3) Extreme body tension accompanied by violent convulsions; often involves sudden heaving and jerking of the entire body; rigidity of legs, with muscles knotted and toes pointed in an extreme manner, muscles of the abdomen hard and contracted, tightly closed or staring, hands grasping, mouth often distorted; body or parts of it twitching spasmodically, sometimes simultaneously with violent jerking of the penis; build up to orgasm gradual and possibly prolonged, with still more violent convulsions; heavy breathing, sobbing, groaning, violent cries, sometimes tears; orgasm often extended, even several minutes of recurring spasms. Aftereffects may not be more marked than with other types; often the male is capable of a second experience.

(4) Similar to type (1) or (2), but including hysterical laughter, talking, possibly sadistic or masochistic reaction, rapid motions culminating in frenzied movement which continue through the orgasm.

(5) Similar to any of the above, but culminating in extreme trembling, possible collapse, loss of color, even fainting.

(6) The individual is pained or frightened at the approach of the orgasm. The genitalia become hypersensitive immediately at and after orgasm. Male may suffer extreme pain or may even scream if penis is touched or movement continued. Sometimes hyper-



sensitivity occurs before the arrival of the orgasm, and the individual will fight away the partner, may try to avoid climax, although they return to complete the experience.

The fourth or final stage is the resolution phase, a period in which the penis detumesces in two distinct stages. In the primary stage involution reduces the penis to a size roughly fifty percent larger than its ordinary flaccid state; this occurs rapidly in most cases. The secondary stage, which occurs much less rapidly, returns the penis to its normal size. Various factors affect both these stages however. Continuing stimulation may prolong both first and second stage involution. The concentration necessary to urinate subsequent to the sexual act may hasten both stages, for instance, although some individuals appear capable of urination with full erection. During this phase, the scrotum regains its folding and the testes are

lowered to original position.

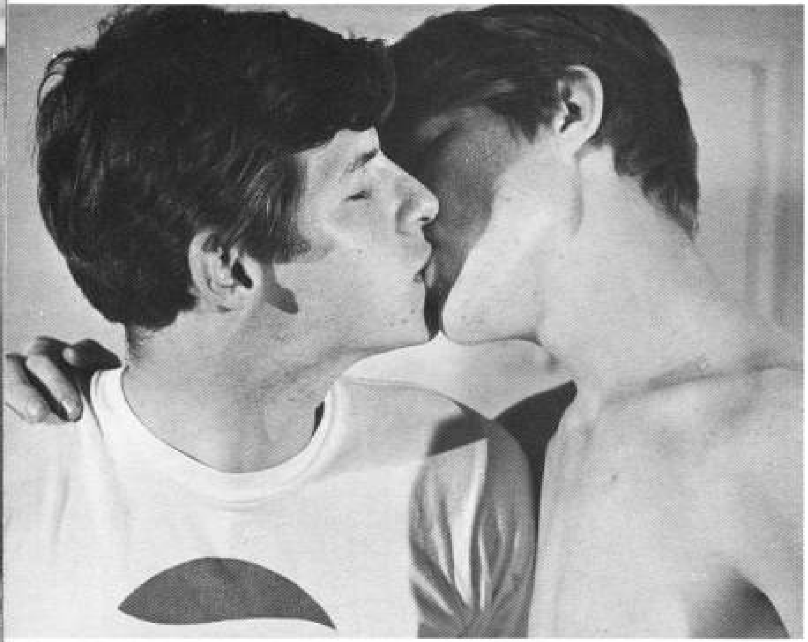
Regrettably, as Masters and Johnson have pointed out, the penis "constantly has been viewed but rarely seen." There has been much misinformation and myth surrounding the penis, and misrepresentation has created a body of phallic fallacies which have clouded our behavior and even our science.

Among the fallacies encountered is the one that the uncircumcised male may establish ejaculatory control more effectively than the circumcised male. This is linked with the related fallacy that the uncircumcised penis is more sensitive to exteroceptive stimuli. Masters and Johnson, testing thirty-five circumcised and thirty-five uncircumcised males of similar ages, found no clinically significant difference in sensitivity between the two groups. It was noted that, of the uncircumcised males, only six failed to demonstrate significant exposure of the glans during

or immediately after coition. Ordinarily the foreskin retracts sufficiently to permit direct exteroceptive stimuli just as in the case with the circumcised penis.

However, the noted researchers concerned themselves primarily with coitus, and themselves pointed out that the same was not the case with masturbation, in which the foreskin does not ordinarily retract as far or as frequently, depending to some degree upon the masturbatory technique. Nor was any mention made of various oral-genital practices common to homosexuals. Probably foreskin retraction in oral-genital activities approximates that in masturbation, while retraction in anal intercourse approximates that in coitus.

The most common question regarding the penis has to do with size, particularly in relation to enjoyment. Penis size will be discussed in relation to oralism and analism in Volume II. In general, size has little



anything to do with sexual prowess or potency. Size may be of more concern to the homosexual lover than the heterosexual lover owing to the greater capacity of the vagina to adapt to size than can the mouth or anus.

Loeb found that the length of the average penis in its flaccid state was 3.74 inches. Other researchers support this measurement.

It has been supposed that the larger penis goes through a larger increase in size in the process of erection. This is mainly myth. Masters and Johnson, measuring men in two groups, one having significantly larger penile measurement in the flaccid state, found no significant difference in measurement when full erection was achieved. Koble and Warren suggest six inches as an average length for a penis in full erection.

There is no documented evidence to correlate penis size to general body size or structure, although myths cite hands, feet, height, ears and mouth, even nose as evidence of penis size. Gilbey and Bross suggest that racial strain may have a bearing on genital size in general. Negroes, by and large, seem to have larger genitals than Caucasians. However, it ought to be stressed that these are only generalities; moreover, where greater size is observed in the flaccid state, it must be remembered that this may have no bearing upon size in an erect state.

There are phallic fallacies as well regarding performance fears and powers. Impotence is too lengthy a subject to go into here; in passing, however, it might be mentioned that impotence more generally seems to be a psychological condition than a physiological one.

Many males wonder about excessive experience, whether it might cause physical strain, loss of strength, neurosis, etc. These may be regarded largely as a result of myth. According to Masters and Johnson, "no study subject could provide a secure personal concept of what constituted frequent or excessive levels of masturbation" What is excessive for one person might be normal for another.

Kinsey states that "such designations, as infantile, frigid, sexually underdeveloped, underactive, excessively active, over developed, over sexed, hypersexual or sexually overactive, and the attempts to recognize such states as nyphomania and satyriasis as discreet entities, can in any objective analysis, refer to nothing more than a position on a curve which is continuous. Normal and abnormal, one sometimes suspects, are terms which a particular author employs with reference to his own position on that curve."

Premature ejaculation can sometimes be a concern for the homosexual male as it can be for the heterosexual. Although there is not the physical necessity of maintaining arousal and erection in order to bring one's partner to climax as there is in coition, the loss of one partner's arousal subsequent to ejaculation can detract from the other partner's pleasure. And, of course, such a loss of erection would render anal intercourse impossible. In any event, premature ejaculation can be overcome.

Relating to heterosexual experience, one suggestion is that as the climax approaches, the male or his partner lightly pinch the glans just below the meatus for a few seconds, withdrawing the penis if this is necessary. This quickly terminates the orgasmic desire without ending the erection, and sex can be resumed. This practice could be easily adapted to homosexual relations. After a few such experiences, the tendency toward premature ejaculation should fade. Two things merit mentioning. This practice may be easier with the receiving partner dominant. Also, it is important that action be taken before the onset of climatic inevitability.

Males also worry about impotence with advancing age, but investigations have revealed that the male can

be sexually active into his ninth decade if his health is good and his partner interested and interesting. Often the male simply fails to realize that it may take him longer to achieve erection. When initial efforts fail, he assumes that continuing efforts will fail, and resigns himself to impotence.

If impotence occurs in an individual's sexual experience, he ought first to assure himself that there is no medical cause. Finding that his health is generally good, he might then simply exercise a little patience, taking more time with foreplay. Nervousness and lack of confidence may produce difficulties as well. A few romantic or encouraging words from the partner may be all that is needed, or even a more romantic setting.

Erotica may help in achieving an erection. Certain sexual acts likewise may be more effective than others. Although anal intercourse may be the goal desired, oral activities may first be used to accomplish erection. If impotence is a problem it is more than customarily important that the male be frank in expressing his preference, what gives him the most

pleasure, etc.

Experimentation in positions may be useful too. A male who cannot achieve erection while lying on his back may have no difficulty in a dominant position. Because human males respond to visual stimuli as well as tactile stimuli, it may be advisable to leave the lights on so that the impotent male may observe his partner's ministrations.

Sometimes a one-time failure, brought about by worry or exhaustion, may produce a mental condition which in itself causes subsequent frustration. In this case, the individual may be better off to forego his efforts and wait for that occasion when an erection does occur, approaching his partner then. This, of course, particularly requires a partner who is concerned with the problem and with overcoming it, as involuntary erection may occur during sleep or on awakening. However, once a successful sexual experience has occurred, even on just one occasion, the mental block may be overcome and the difficulty dissipated.

GAY SEX TECHNIQUE: MASTURBATION

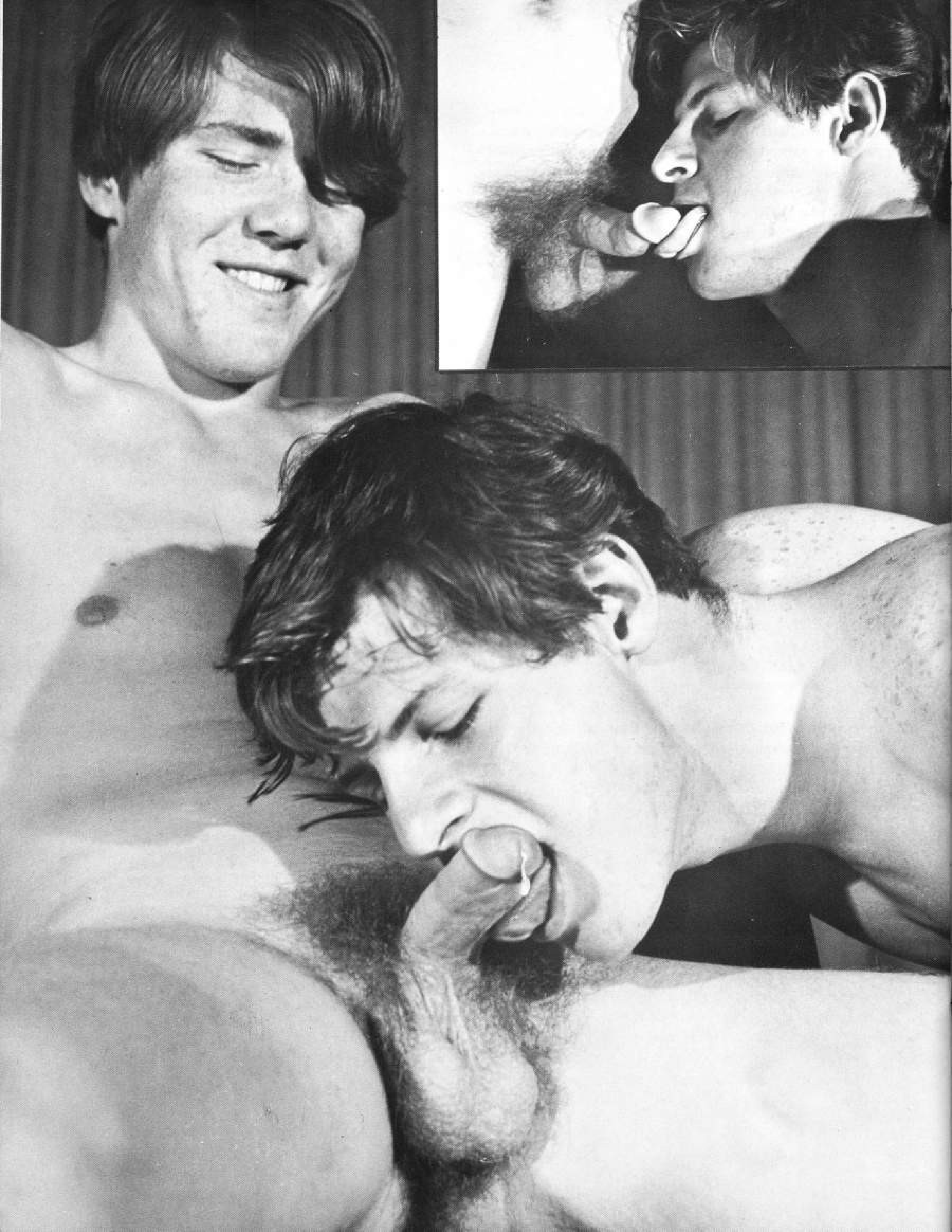
Masturbation, in its simplest form, refers to manipulation of the penis, usually culminating in sexual orgasm. Kinsey, in his Sexual Behavior of the Human Male, defines masturbation as follows:

"The term masturbation may be applied to any sort of self-stimulation which brings erotic arousal. Since all tactile responses and still others of the sensory responses are basic to sexual activity, there is considerable justice in extending the concept of masturbation to all situations in which there is tactile stimulation. As more usually employed, the word masturbation refers to any self-stimulation which is deliberate and designed to effect erotic arousal. By such a definition, the accidental touching of oneself is not masturbation because it is not deliberate. As so defined, not only tactile stimulation, but all other sorts of sensory and psychic stimulation, if deliberate and designed to bring satisfaction, fall under this head."

The shortcoming of this definition, unfortunately, is its insistence upon the term "self-stimulation." Koble and Warren are quick to point out that masturbation need not be limited to self-perpetration, i.e., one person can masturbate another, or two individuals can engage in mutual masturbation of one another.

Most of what has been written upon the subject deals with masturbation as a solitary act, self-perpetuation. In our context, we are concerned with acts perpetrated in the company of another and/or on the person of another. It is true that an act of solitary masturbation engaged in while fantasizing homosexual acts can be categorized as a homosexual experience, but we have not found that it has any particular relevance here.

The masturbatory technique of moving the penis against a bed or other objects, mentioned in various works on the subject, is likewise of no particular interest here; on the other hand, a highly similar experience, the so-called Princeton Rub, a body embrace in which the partners rub their bodies together, stimulating the penises sometimes to climax



and sometimes as a prelude to other activity, is included here. It is also true that homosexuals quite frequently masturbate or are masturbated while engaging in anal or oral acts with a partner, but these activities will be more appropriately covered in Volume II.

Masturbation is almost a universal practice among males, whether homosexual or heterosexual. Kinsey found that ninety-two percent of the total male population indulged in masturbation. Other researchers have suggested that the incidence is one-hundred percent.

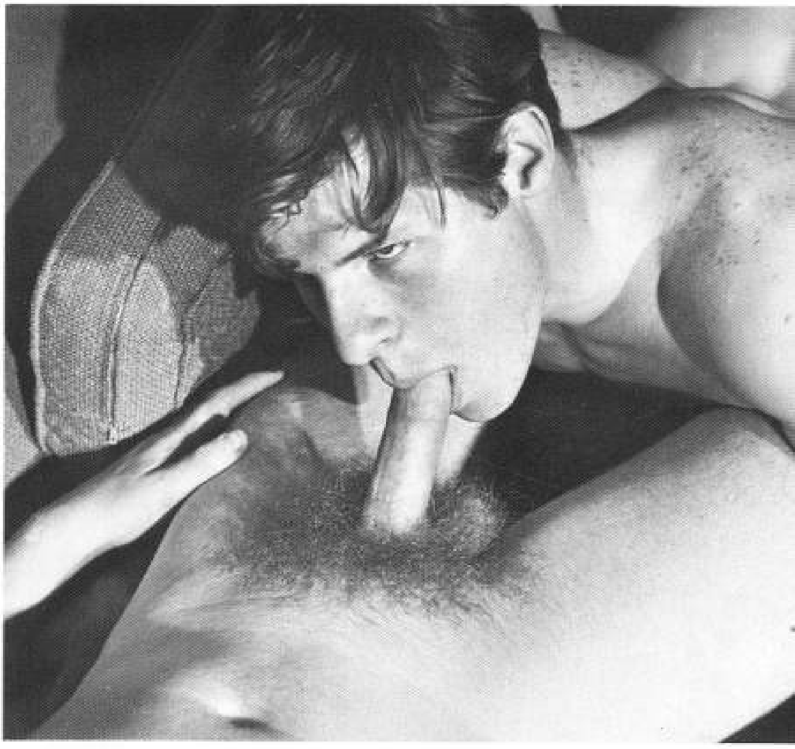
Masturbation in the male generally centers upon the penis and the scrotum, with less emphasis on the rectum. Techniques are largely manual, constituting deliberate attempts to provide genital stimulation to the point of orgasm, although masturbation may be a prelude to other activities, or a means to achieving an erection. Masturbation is probably employed in nearly all homosexual contacts, if for only a few seconds, regardless of what form of activity follows. Likewise masturbation is a form of activity employed by males experimenting with homosexual contacts but reluctant to engage in oral-genital or anal-genital activities. With these factors in mind we can see that masturbation is probably the most common form of homosexual contact.

Males develop their own individual masturbatory techniques, which vary widely. Some men employ only a light touch on the ventral (underside) surface of the penis while others utilize a firm grip on the entire shaft. Some stroke the glans, specifically rubbing with the thumb. Some jerk upward and outward with each stroke as though violently stretching the penis. Some men hold the penis with the thumb and one finger, others use the entire hand. There are countless gradations of firmness of grip, speed, and violence of strokes.

Most commonly, masturbation concentrates on the shaft of the penis. Masters and Johnson found that "stroking techniques rarely move sufficiently distal on the shaft of the penis to encounter more than the coronal ridge of the glans even late in the plateau phase just before ejaculation."

In the late plateau level, the masturbatory strokes become more rapid. As ejaculation begins, however, there is again a wide difference in reaction. Most males slow down their stroking movements markedly, or cease them altogether. Many tend to grip the shaft just below the glans in a spastic constrictive movement.

Immediately after ejaculation the glans ordinarily



becomes sensitive to touch, sometimes to a painful degree.

Some males prefer or even require some form of lubrication on the penis during masturbation, ranging from petroleum jellies to saliva; others find the use of such lubricants inhibiting.

In general, the forms of activity with which we are concerned are five:

1. self-masturbation with a partner watching
2. self-masturbation while engaged in embraces with a partner
3. masturbation of one's partner
4. mutual masturbation by two or more individuals
5. rubbing and other bodily embraces

Self-masturbation with a partner watching is only slightly removed from solitary masturbation, with the added factor of exhibitionism and voyeurism. There is little needed in the way of instruction, as a male would normally tend to employ that technique most to his own liking. All of the varieties of devices, positions, etc., are possible, which have been discussed at some length in a number of volumes.

When embraces, kissing, fondling, etc., are added to self-masturbation, a shared experience develops. In most instances the experience which begins in this manner will graduate from self-masturbation to masturbation of one another, and possibly other activities. As above, the individual will by instinct choose that technique most satisfactory to himself. If it is desired that masturbation of one another follow, each partner has a valuable opportunity to observe the other, and in so doing see for himself what technique is preferred by his partner.

As to positions, almost any position can be satisfactory, depending upon each individual's own preference. It might be noted here that this form of activity may follow as well as precede other activities. If, for instance, one of the individuals in a sexual liaison achieves orgasm significantly before the other, the other may choose to masturbate to climax while his spent partner fondles and kisses him to increase his enjoyment of the masturbatory act.

It is when we come to the third of our activities, masturbation of another, that the matter of tech-

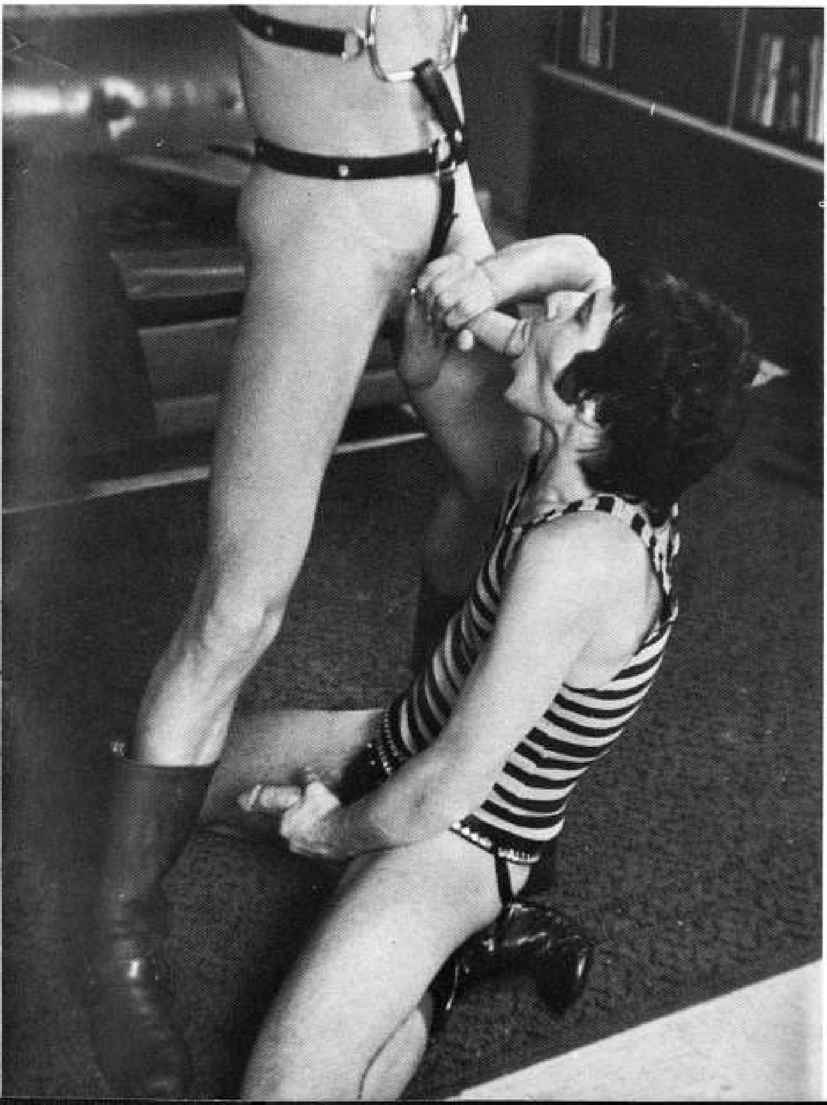
nique actually becomes of consequence. Here one must rely not upon his own preference, developed through his solitary masturbatory experiences, but upon the preferences of the recipient, which may be completely different. Frankness in conversation is a good idea in this as well as in all sexual experiences. Even without conversation, however, an observant lover can soon become attuned to his partner's likes and dislikes.

If this experience has been preceded by self-masturbation, each individual would have given some indication of his preferred technique. There are physical reactions for which the masturbator can watch as well, which would give clues to his success in providing pleasure. Generally, sudden spasmodic and erratic movements in the region of the lower abdomen or the upper and inner thighs, with or without an accompaniment of low moans, suggests that the partner is enjoying what he is experiencing. Conversely, powerful flexing of stomach and thigh muscles may suggest that the pressure being exerted on the penis is uncomfortable.

The safest approach for the masturbator would be the most conventional one, a light grasping of the shaft of the penis in the fist, with gentle, regular strokes up and down. The partner's subsequent movements may provide clues to varying the activity. Some partners enjoy having the glans rubbed lightly with the palm of one hand while being masturbated by the other hand.

Again, masturbation can be accomplished with kissing, embraces, fondling, etc. Stroking the testicles, or light squeezing, especially done with a gentle rolling motion while resting the testicles in the palm, may enhance the experience for some. The perineum, extending from behind the testicles to the rectum, is also sensitive, and gentle stroking or tickling of this region is frequently helpful.

The rectum, too, is especially sensitive to erotic touches. Some males may object to the inserting of a finger, others will find this exciting. In the former case, objections may be psychological, a fear of a loss of masculine status. With repeated experience this objection may vanish. On the other hand, the



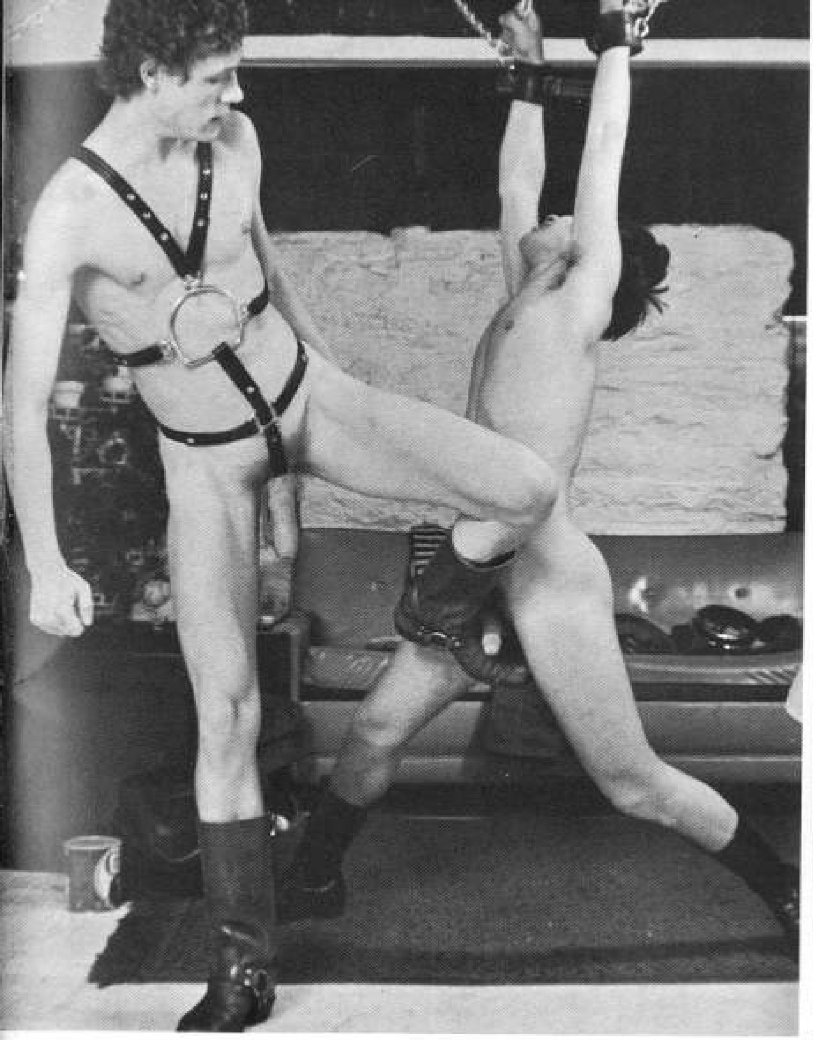
difficulty may be physical. In either case, the partner who finds such insertion uncomfortable will generally make this known by moving away from the finger. Even where insertion is not desirable, however, gentle massaging of the anal region and the buttocks, in general, will tend to add to sexual arousal for nearly any male, the anus and buttocks being, as they are, generously supplied with nerve endings and erogenous zones.

The erogenous zones have been touched upon before in this volume, and they do vary from one individual to another, so that no hard and fast rules can be laid down. The breasts have been mentioned previously, and the masturbator might experiment with these to see if their massaging increases or decreases the partner's sexual tension. The ear lobes and the ear opening itself, the chin and the neck, the inner surfaces of arm and leg, the armpits, the abdominal region just inside the curve of the pelvic bone, and pubic arch, all are erogenous zones in a number of people. The skillful lover remains constantly alert for signs of pleasure in one's partner as he touches these various regions, or any indication that the partner may want another area massaged or fondled. One ought not be embarrassed to ask a partner if he does or does not like a particular touch or action.

Needless to say, oral contact with any or all of these erogenous zones can be exciting as well, but these belong more properly in the section dealing with oral activity which appears in Volume II. Since the human male is highly susceptible to visual stimuli, it would probably be desirable to leave the lights on, dimly, during such an experience; but if this makes either partner uncomfortable, then of course it would be as well to do without them.

While masturbating his partner, the active individual may also choose to masturbate himself.

The question of whether to continue masturbation to climax or discontinue this practice in favor of other sexual activities can only be answered by the whims of the two partners. For some individuals the experience of having a partner ejaculate upon one's person, as upon one's chest, for instance, is an exciting one; for others it may be distasteful. The one being masturbated can easily indicate his preference: by drawing away prior to ejaculation; by thrusting bodily to encourage further masturbation; by pushing against his partner's head to encourage mouth-genital contact, and so on. Or the active partner, the masturbator, may be the one to initiate something further.



The active partner should be alert for signs of impending orgasm if masturbation to climax is not desired. If the two are frank and relaxed with one another, the warning may be verbal. However, a pulling away from the active hand, an increase in twitching and writhing, heavier, more rapid breathing, all indicate the approach of orgasm. A sudden increase in size and rigidity, and a swelling and hardening of the glans, indicate that an orgasm is imminent, and that orgasmic inevitability has probably set in. Ceasing activity now will not prevent orgasm, and may only make it less pleasurable for the receiving partner.

Nearly all of the above is equally applicable to mutual masturbation. Primarily, the difference is that, rather than each partner masturbating his own penis, or one partner assuming an active role, the partners assume equal roles here, each grasping and manipulating the penis of the other. Embraces are almost unavoidable now, although the act can be

achieved lying side by side, facing in the same direction, or in opposite directions, in a position similar to that employed in the so-called soixante-neuf form of orality.

In a variation of mutual masturbation, one partner may choose to stroke both organs. To do so, he would engage his partner in a close embrace, placing his penis alongside the penis of his partner. They can be lying face to face, or one partner can be on his back, the other straddling him. The active partner can simultaneously clasp both penises. This affords not only manual contact with the penis, but the additional contact of another organ which some find very stimulating.

This technique seems particularly effective if one of the partners has experienced some difficulty in achieving full erection; the close contact, perhaps the power of suggestion, seems to be helpful in overcoming this difficulty. Sexual arousal is a contagious condition. Again the partners must decide, individually or jointly, whether to climax in this position or progress to other forms of sexual activity.

Excepting the guilt factor which sometimes accompanies it owing to our puritanical background, masturbation is not a harmful act, and ought to be properly looked upon not as a substitute form of sexuality, but as an alternative. If two individuals, or even one of them, prefer masturbation as a form of sexuality, there is no reason why they should not so indulge themselves. Even where other forms of activity are preferred, masturbation can provide a change of pace, as it were.

There are circumstances, too, where a couple may not be able to perform as they normally do. Hygienic circumstances—a throat infection, for instance—may prevent a homosexual pair from engaging in the oral or anal practices customary to them, and masturbation may be the solution for one or both.

It might be mentioned here as well, that there are numerous variations on the above that individuals may want to consider. For instance, any of these forms of activity could occur out of bed, in water, for example. Many homosexuals are particularly aroused by performing sexually in the shower or bathtub. Any of the above could combine with massaging, body rubbing, and oral and anal contacts in such settings. In addition to the ministration of one's partner, the water itself seems to provide an overall body caress which many find exciting. Other homosexual pairs enjoy sexual activities on unusual sur-

faces—a fur rug is frequently mentioned. Again the skin of the body, almost any part of which can be erogenous, receives tactile stimulation over large areas.

There is a form of sexual activity included here called body rubbing. It takes on various forms. Almost any position can be utilized. The two partners may be face to face, penis against abdomen. They may be front to front but in reversed positions, as in sixty-nine. They may be back to back, simulating anal intercourse. The pleasure for the passive or receiving partner is less, but stimulation of the scrotum, perineum and anal area provides some enjoyment, and in a face-to-face position the passive partner's penis may be pushed against the abdomen of the active partner, providing simultaneous gratification for both.

In addition, many individuals enjoy actual wrestling bouts, the combination of physical exertion and body contact providing sexual excitement, sometimes to orgasm.

In any or all of these variations, enjoyment and comfort may be heightened by the use of a lubricant over part or all of the body. A common homosexual activity is the use of a lubricant, such as baby oil, preparatory to a lengthy and strenuous bout of wrestling, rubbing, embracing, etc., often performed upon a nonabsorbant surface such as a rubber sheet or a large piece of plastic material. Other couples have been known to experiment with substances such as whipping cream, from an aerosol container. Almost any substance that provides lubrication could be utilized; various suntan lotions have been mentioned as well.

A question frequently asked by the uninformed is, "What would two men do together?" The fact is, homosexual activity and response, specifically male, has a greater and wider range than either female homosexual or heterosexual activity. Heterosexuals would deny this immediately, however, the fact is that an active male partner can indulge in oral-genital activity while he indulges in anal-genital intercourse thus providing both himself and his passive partner the ultimate in sexual gratification.

While attempts have been made herein to categorize certain acts, it must be strongly pointed out that man is not a series of categories, neatly put in order of response, but a total creature. He may respond in any part, under any circumstance, to any stimuli. Despite its definition, masturbation need not be merely a matter of stimulation of the penis. Properly approached and perpetrated, it can be as total an experience as any other.

GAY SEX TECHNIQUE: MASTURBATION AND SADO-MASOCHISM

Research into the area of sado-masochism has been very little in the past, however, this area is experiencing more attention as researchers delve into the realm of sexuality. We shall deal here with only those activities which are both sado-masochistic and masturbatory.

Sado-masochistic activity has the element of pain which for some individuals also gives pleasure. It has been reported that one of the most common forms of this behavior is when the active partner, standing behind his passive partner, masturbates the passive partner while he slaps his buttocks either with his hand, leather belt or whip. Individuals who indulge in such activity relate that the slapping or whipping of the buttocks while being masturbated gives unusual pleasure. They prefer this method to standard masturbatory practices because the whipping seems to send sparks through their body, so they report.

Other sado-masochistic activities coupled with masturbation include: the active partner stands over his partner, he holds a dripping candle and directs the hot drippings onto the chest, abdomen and legs of his partner who is masturbating. The passive partner usually accompanies this activity with his favorite fantasy; an active partner may also tug on the testicles of his partner while he or his partner strokes the penis. Other homosexual sado-masochistic activity coupled with masturbation includes the use of rings, usually metal or leather which are placed at the base of the penis. These are used for tugging the penis while the other partner masturbates it.

The range of this behavior is so wide that it would be impossible to enumerate each individual instance and method. It can be said that activities of this type usually involve implements, such as whips, belts, clothespins, etc. The purpose of the activity is to give pain along with the end result of ejaculation.

Again, it must be stated that masturbation need not be merely a matter of stimulation of the penis but can be a total experience as any other.

Chicago

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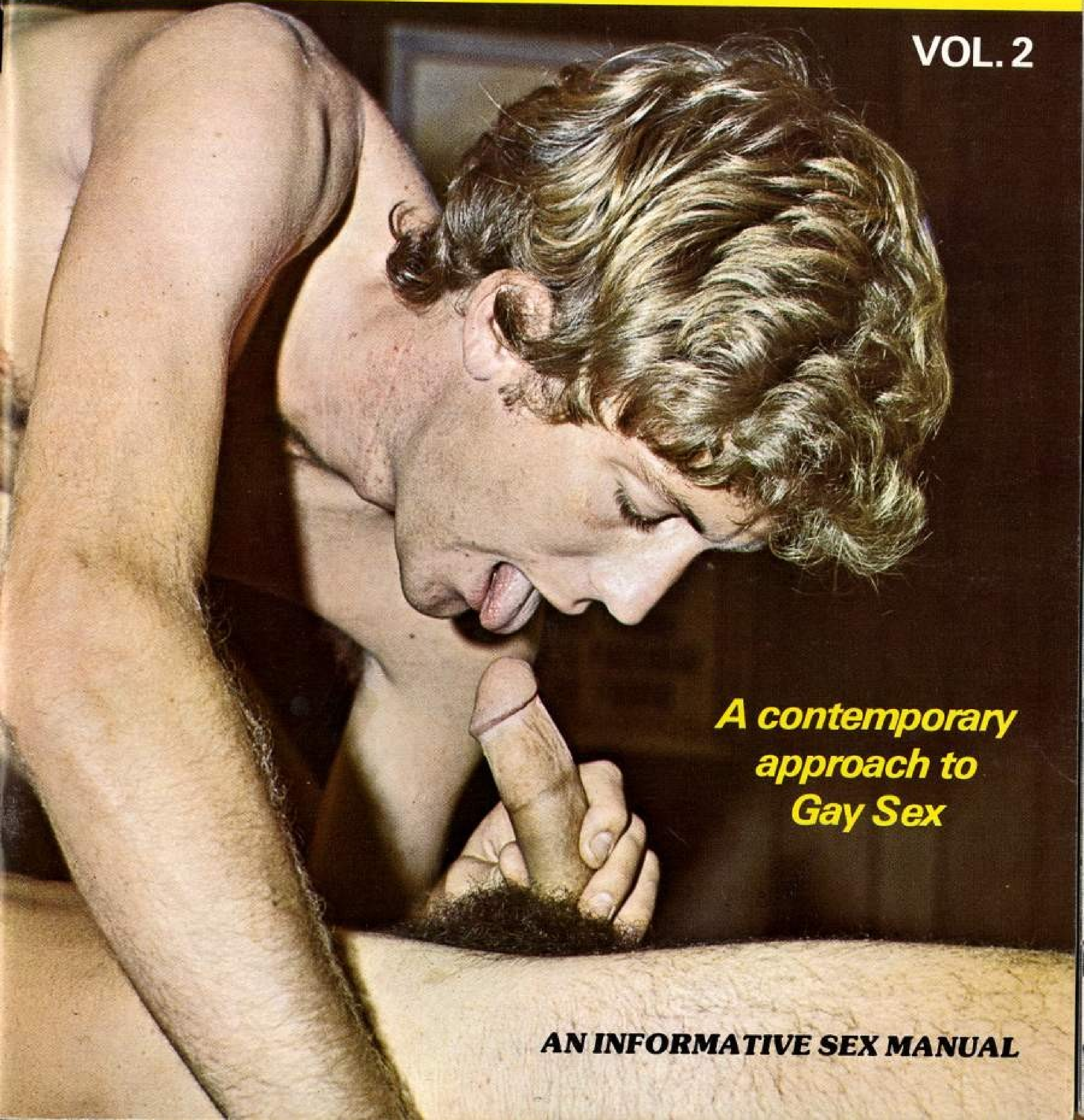


VOL. 2

A contemporary approach to Gay Sex

AN INFORMATIVE SEX MANUAL

THE MALE HOMOSEXUAL
INTRODUCTION

The first awareness of an individual's actual admitting to himself that he is homosexual is often an emotionally supercharged and extremely difficult time. Most react with the feeling that it is a purely transitory phase. Many fight against it, and are unwilling to recognize that their homosexuality is either permanent or inevitable. Some feel that they are odd, or outcast, or unique in some way, until they meet another homosexual who, in turn, can introduce them to other homosexuals.

It is impossible to give any quantitative analysis of the various ways a person realizes that he is homosexual. With freer knowledge and discussion, some authorities are afraid that we will produce statistical homosexuals, i.e., those who have read about it, experienced no guilt about their first contacts, and who then become practicing homosexuals, unwilling to investigate heterosexual outlets. But with more discussion and education, this air of finality seems unlikely.

ANALISM: DEFINITION AND MOTIVATION

Anal coitus, or coitus per anum, is the insertion of the male member into the rectum of another. The act has many names, e.g., Turkish Style, Greek Method, Russian Style, but more generally the practice is referred to as sodomy.

Anal intercourse is hardly an invention of the twentieth century; it has been practiced ever since the beginning of man. It is found recorded both through words and pictures in the earliest histories of ancient Greece, Imperial Rome and the lands of the far east. It has been, and still is, practiced by royalty and commoner alike, statesman, philosophers, educators. In fact, many Roman Emperors were addicted to the practice, usually with young boys.

Although anal intercourse is far from being an exclusively homosexual phenomenon, the practice holds a certain fascination for the overt homosexual simply because the massaging of the prostate gland induces many males to accomplish orgasm. Further, in homosexuality, the practice of anal coitus by two males is closely allied to heterosexual coitus.

The anal region has long been recognized as an important erogenous zone in almost every normal adult, even though many individuals refuse to recognize this fact. Masters and Johnson, in their Human Sexual Response, state the erotic component of the male genitalia has been concentrated in external pelvic anatomy and the penis, scrotum, and rectum are markedly sensitive to sexual stimulation. There is an intimate relationship between the nerves of the intestinal and rectal tract and those of the genital region. Many men find it difficult to achieve an erection without the insertion of something into the anus and the man is rare indeed whose enjoyment of coitus, heterosexual or homosexual, is not enhanced by some form of anal stimulation.

Before getting into the various techniques employed in performing anal intercourse, let us first consider the psychological motivations that led to the practice.

Dr Sigmund Freud contended that sexual desire is rooted to the earliest stages of infancy. He said that a comprehensive study of the sexual manifestations of childhood would probably reveal to us the essential features of the sexual instinct and would show us its development and its composition from various sources.

As regards anality, Freud stated that the anal zone is, through its position, adapted to produce an anaclisis of sexuality to other functions of the body. It should be assumed that the erogenous significance of this region of the body was originally very strong. Through psychoanalysis one finds, not without surprise, the many transformations that normally take place in the sexual excitations emanating from here, and that this zone often retains for life a considerable fragment of genital irritability.

The intestinal catarrhs which occur quite frequently during infancy produce sensitive irritations in this zone and we often hear it said that intestinal catarrh at this delicate age causes nervousness. In later neurotic diseases they exert a definite influence on the symptomatic expression of the neurosis, placing at its disposal the whole sum of intestinal disturbances. Considering the erogenous significance of the anal zone which has been retained at least in transformation, one should not laugh at the hemorrhoidal influences to which the old medical literature attached so much weight in the explanation of neurotic states.

Children utilizing the erogenous sensitiveness of the anal zone can be recognized by their holding back fecal masses until through accumulation there results violent muscular contractions; the passage of these masses through the anus is apt to produce a marked irritation on the mucous membrane. Besides the pain, this must also produce a sensation of great pleasure. One of the surest premonitions of later eccentricity or nervousness is when an infant obstinately refuses to empty his bowel when placed on the chamber and controls his function at his own pleasure. It naturally does not concern him that he will soil his bed; all he cares for is not to lose the subsidiary pleasure of defecating. Educators have again shown the right inkling when the designate children who withhold this function as "naughty."

The content of the bowel which acts as a stimulus to the sexually sensitive surface mucous membrane, behaves like the precursor of another organ which does not become active until after the phase of childhood. The retention of fecal masses is at first intentional on the child's part in order to utilize them, as it were, for masturbatic excitation of the anal zone, although the infant is, of course, not cognizant of the fact that the act is of a sexual nature. However, real masturbatic irritation of the anal zone by means of the fingers, evoked through either centrally or peripherally supported itching, is not at all rare in older children.

Freud further contended that analism stems from the individual's desire to imitate a gratification which was once experienced in connection with other organic processes.

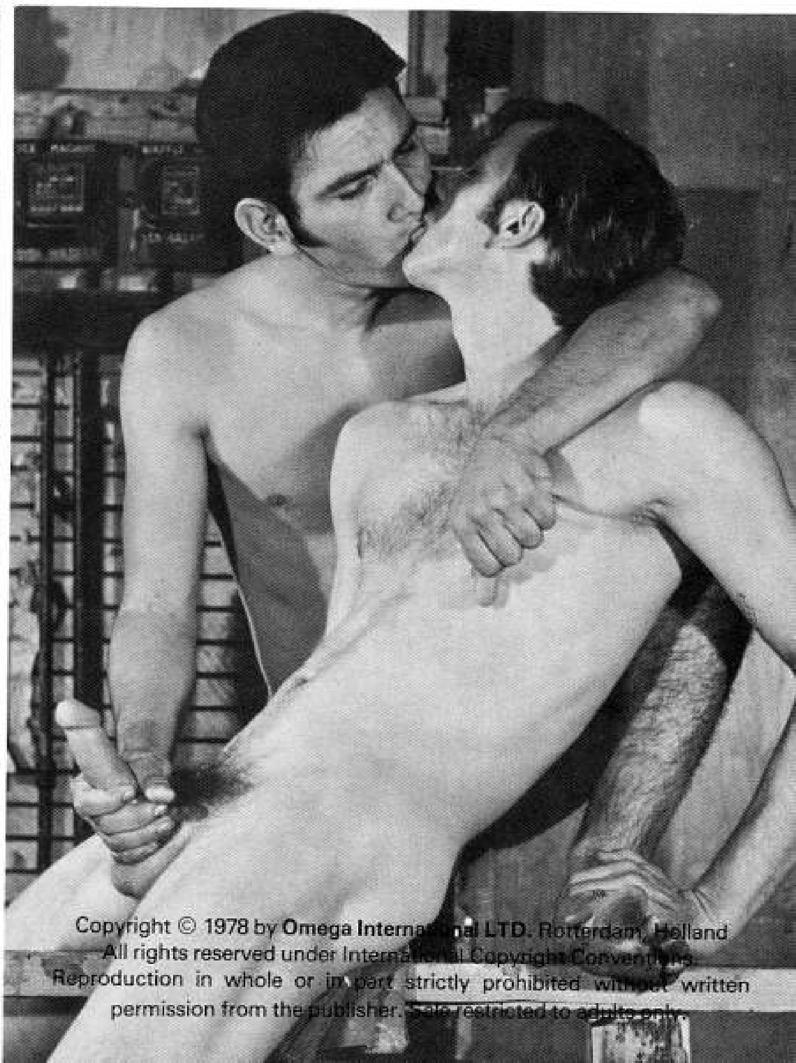
ANAL INTERCOURSE TECHNIQUES

Setting aside the psychological motivation for the practice of anal intercourse, let us now deal with the various techniques and methods, positions, variations, etc., that are employed by the male homosexual in performing the act.

But even prior to any discussion of the various positions, mention must be made of the preliminaries that need to be exercised when leading into anal intercourse. The very first consideration must be respect and love for one another. As Bertrand Russell said: "Morality in sexual relations, when it is free from superstition, consists essentially of respect for the other person and unwillingness to use that person solely as a means of personal gratification without regard to his desires."

If two males agree to engage in anal intercourse they must have a regard, a high respect, one for the other if the ultimate in sexual pleasure is to be realized from the act. Respect will automatically generate concern; concern will produce caution and extreme gentleness which are absolutely essential elements in the practice of anal intercourse.

The partners should first want to perform anal sex. It should not be forced upon an unwilling partner. It should be discussed by both parties beforehand, and both parties should be eager and willing to engage in the act. After a rapport has been established between the partners, then "circumstances" should and must be taken into account. For example, if two male



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homosexuals desire to engage in anal intercourse, it would hardly be pleasurable if they were to perform the act on a sandy beach, or in a room where they might be subjected to constant interruptions. Privacy and comfort are prerequisites; these two factors will do much to put the partners in the proper frame of mind so they might derive the ultimate sexual satisfaction from the act. When anal intercourse is to be accomplished or attempted for the first time, it is particularly important that "preliminaries" receive strict attention. The proper atmosphere must be established: soft music, dim lighting, etc. A romantic milieu may do much to offset first-time nerves.

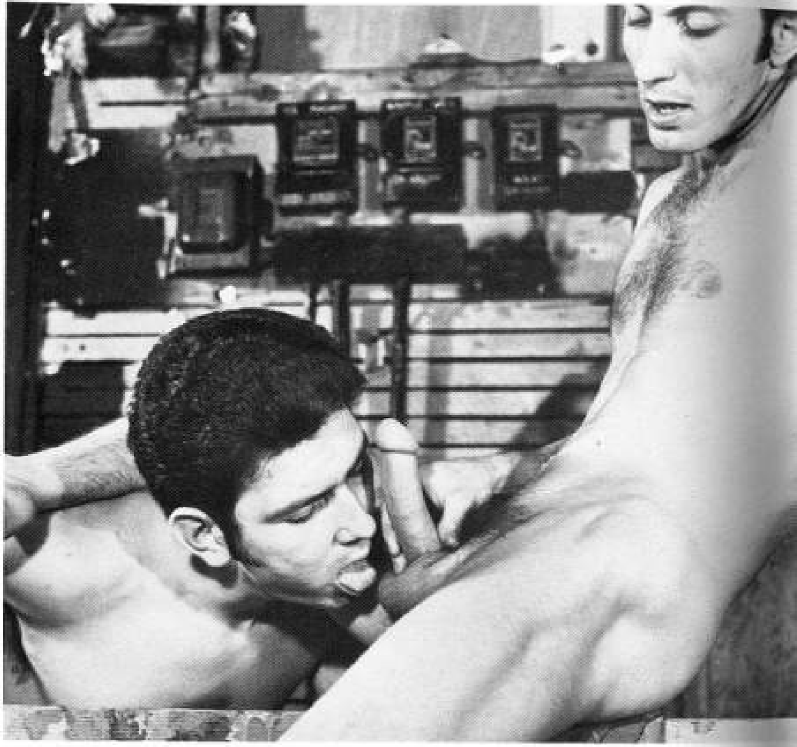
After the proper atmosphere is established, the next aspect to be dealt with is the approach. As stated before, a slow, gentle approach is of the utmost importance. Although there are some individuals who can accommodate any size, shape, or description of male sex organ, most individuals should insist upon cautious, gentle treatment when assuming the passive role.

A great deal of damage can be done if the act is not performed properly. The walls of the large intestinal tract are extremely vulnerable to puncture and it is for this reason that the insertion of any sharp or pointed object into the rectum is vehemently frowned upon. The penis, if positioned properly and inserted correctly, can cause little or no injury to the intestinal walls.

The sphincter muscles of the anus must be relaxed fully in order to permit entry of the penis. In order to relax these muscles the passive partner must himself be fully relaxed. This can be easily accomplished by gentle caresses, kissing, stroking, etc. These points, however, will be more fully covered in the sections of this text which deal directly with the oral aspects of homosexual love.

Digital manipulation and stroking of the lips of the anus is very important during the necking and kissing stage. The active partner should fondle and caress the buttocks, gradually working his way between the cheeks of the buttocks, parting them gently and slipping his fingers into the cleft. The anal opening should not be the target of a direct attack by the fingers; the perineum should be concentrated upon first.

The perineum is that area between the anal opening and the base of the testicles sac. It is a high level zone for stimulation in the male—the base of the penis continues to its base root through the perineum and, therefore, stimulation in this area will often carry through to the nerves in the penile base. Stroke the perineum, expanding your stroke from time to time so that the fingertips brush lightly against the lips of the anus. When the passive partner has fully relaxed, a more concentrated caressing of the anal opening should then commence.



Whenever anal penetration is contemplated, a lubricant of some type should be readily available and should always be used. There are some individuals who have been known to "secrete," thereby producing their own natural oils in the rectal area, but such individuals are extremely rare. It is advisable in any case to use a commercial lubricant, such as K-Y, Vaseline, Abolene, other oils and if none is at hand saliva will do fine. In fact one famous homosexual said, "If it isn't with spit, it isn't love!"

BACK-TO-FRONT POSITION

It seems generally agreed upon among homosexuals that in initial experimentations with anal intercourse the position most favored is the front-to-back position. The passive partner or insertee lies on his stomach with the active partner or inserter positioning himself on the passive partner's back. The legs of the passive partner can either be spread apart or held close together, although the spreading of the legs, the parting of the thighs, will permit the active partner easier access to the anal opening.

In this position the passive partner can cradle his head in his arms, turning his face to the side, so that the active partner has the opportunity of regarding the facial expressions, searching for any signs of discomfort, pain, or any other undesired reaction.

The active partner may, if he so desires, place his entire weight upon the back of his partner, or he may hold himself up from his partner by supporting himself on his hands and arms. Many passive partners place a pillow under their hips causing elevation of the posterior buttocks, thereby permitting easier access to their anal channel.

This front-to-back position is sometimes held in disfavor by homosexuals due to the fact that, depending upon the size and curve of the penis, contact is not made with the all important prostate gland. Ordinarily the penis curves upward in a slight arc when fully erect and, therefore, in the front-to-back position, can bypass contact with the prostate gland when inserted into the rectum while the inserter is reclined on the back of the passive partner.

However, one advantage that should be made mention of is that the front-to-back position enables the active partner to see the anal opening, and to take charge of positioning the head of the penis against the lips of the anus without blindly probing and probing. Too many passive partners complain that they be-

come extremely tense and lose the desire for anal penetration simply because of the delays incurred by the active partner's inability to gain entry quickly and easily.

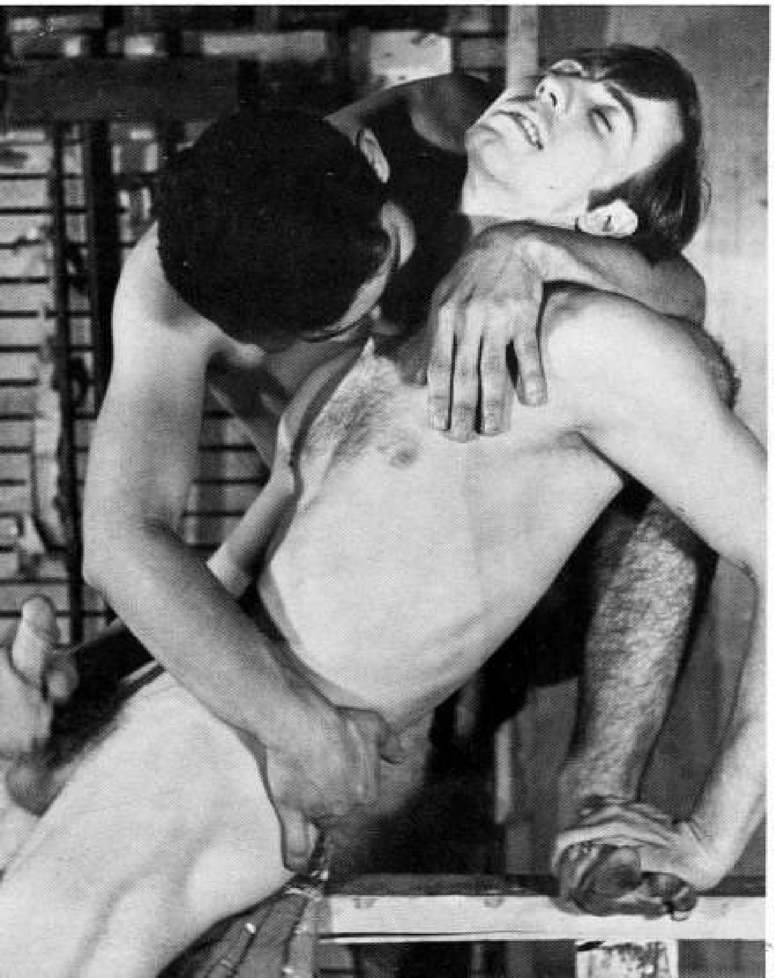
Insertion of the penis into the anus should and must be done as gently as possible. The active partner, holding the shaft of his penis in one hand, fits it between the cleft of the buttocks and against the lips of the anus. He should then place a minimal amount of weight against the opening, thereby loding the glans, or the head of the penis, in place. The glans should be well lubricated, as should the opening of the anus. After the glans is fitted snuggly against the anal opening it should be pushed very gently into the rectum. This can easily be accomplished by the active partner pushing his hips forward, thus exerting pressure against the opening and allowing the glans to slip in between the lips of the rectal opening.

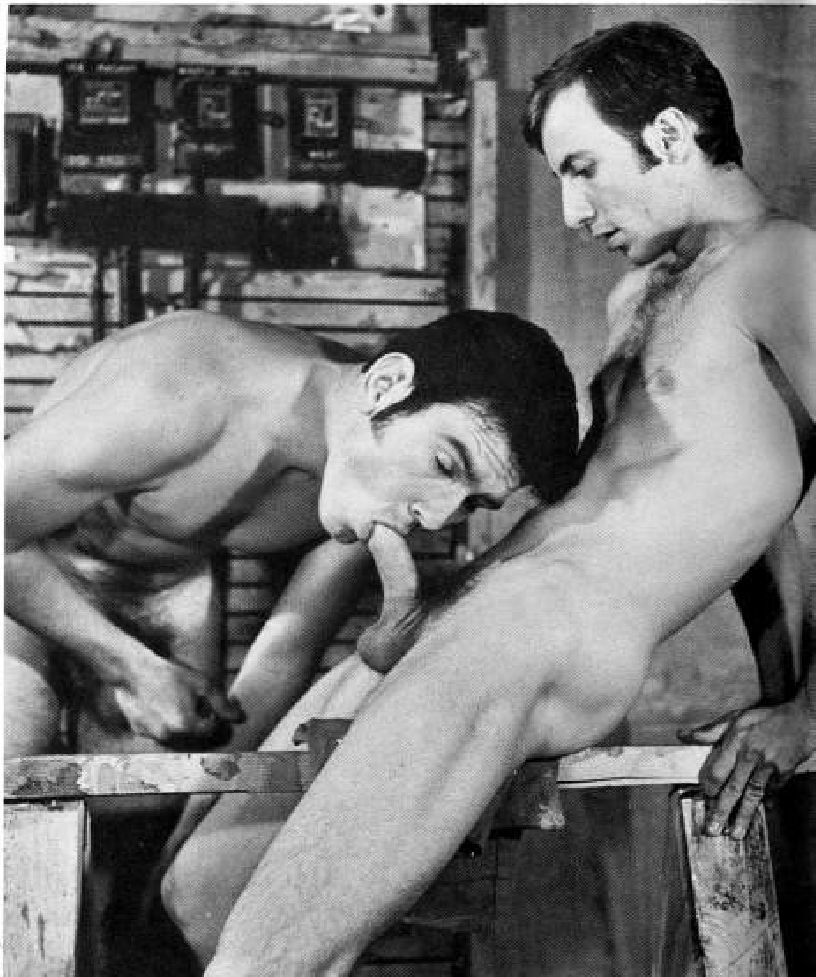
If the passive partner is experiencing anal intercourse for the very first time, care should be taken that the penis does not penetrate too deeply when initial admittance is gained. The opening of the anal channel should be accomplished as gently and slowly as possible, as a slight degree of pain usually accompanies the initial introduction of the glans into the rectum.

Many passive partners often require the extraction of the penis from the rectum so that they are given the opportunity to relax their sphincter muscles and relieve the sharp pain that is produced by the penis into the anal channel. The passive partner should never be hesitant about letting the active partner know that he is experiencing pain. The active partner should obey with delay or question whatever requests or instructions are given him by the passive partner when experiencing pain.

When the passive partner gives permission to continue, and assuming that the passive partner requested the active partner to remove his penis from the anus, the active partner should again position the head of his penis against the opening of the anus. He should press forward, allowing the glans to reenter the rectum.

The second assault is usually much more comfortable for the passive partner; the pain is generally minimized if the passive partner has allowed himself to become fully relaxed. It has been found that if the passive partner pushes outward, as though relieving his bowels, while the head of the penis is entering the rectum, the level of pain will be diminished. An outward pushing motion will help stretch the anal channel; the penis will enter more easily.





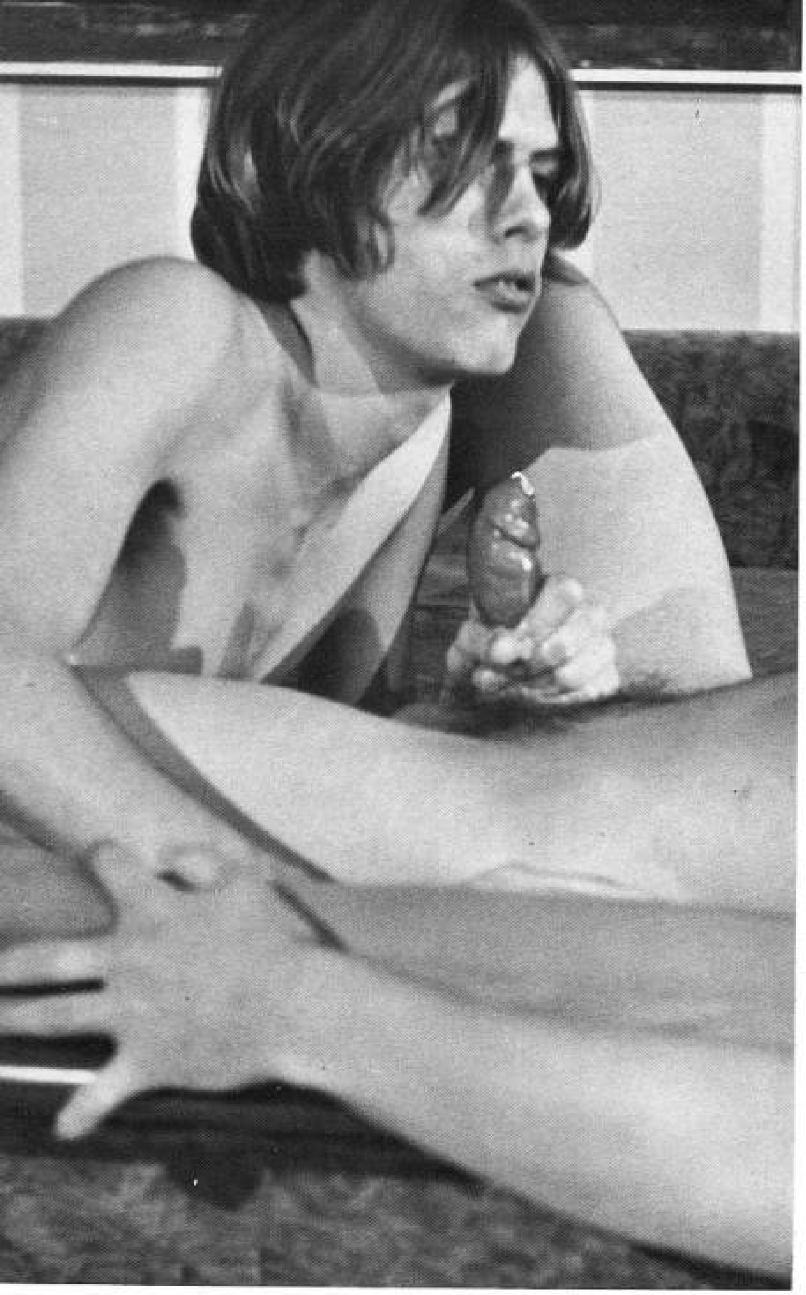
It is sometimes recommended that the active partner remain motionless after positioning the head of his penis against the anal opening, and allow the passive partner to push backward and upward against the active partner. By so doing, the passive partner will be able to gauge the amount of pain (if any) suffered by the insertion of the penis into his anal opening.

Once penetration is achieved and the passive partner is relaxed and desirous of anal intercourse, the active partner should raise his hips from atop the passive partner's buttocks, withdrawing the shaft of the penis part way out of the rectum. The raising and lowering of the hips of the active partner should be done slowly and with measured, even rhythm.

As the passive partner becomes more and more accustomed to the intrusion of the penis into his rectum, the active partner may increase the tempo of his up and down movements. The passive partner will sometimes push backwards against the lap of the active partner.

Most homosexuals consider it important that orality be practiced during the act of anal intercourse. The active partner should repeatedly kiss the back of the passive partner's neck, shoulders, ears.

Further, during the act of anal intercourse in this front-to-back position, it is recommended that the passive partner raise himself up onto his knees and hands in order to permit the active partner (or himself) to perform masturbation upon him.



FACE-TO-FACE POSITION

The basic face-to-face position assumed by male homosexuals is the one that comes closest to resembling the coital position assumed by a heterosexual couple, i.e., the recumbant partner positions himself on his back with his legs either entwined around the waist of the dominant partner or draped over the shoulders of the dominant partner; the dominant partner kneels between the legs of the passive partner and crouches over him.

This position seems to be held in the highest degree of favor among homosexual males, although there are some homosexuals who find the position to be most uncomfortable. The one objection most often expressed rests largely on the fact that penetration of the anal canal is more difficult to achieve and it is usually the passive partner who must take the initiative by grasping the penis of the dominant partner and fitting it into the opening of the anus.

The manner most utilized for accomplishing penile-anal penetration with the least amount of discomfort and delay is to have the recumbent male pull his knees up under his chin (the upper leg tight against the chest), parting the legs slightly, and place most of his weight on the upper back and shoulders area.

A pillow can be used under the hips if so desired; this would elevate the buttocks, allowing the dominant partner easier access to the anal opening. The recumbant male should hold this position until the dominant male has sufficiently lubricated the penis and anus (if this has not already been done). If the recumbant male finds it too difficult or too uncom-

fortable to hold his knees up in this fashion he should rest his soles of his feet against the shoulders or chest of the dominant partner, supporting himself, at the same time raising his buttocks so that the penis can gain entry to the anus.

It is advised that the penis and the anal channel be well lubricated and, it is suggested that digital penetration of the anus be accomplished prior to attempting penetration of the rectum by the penis.

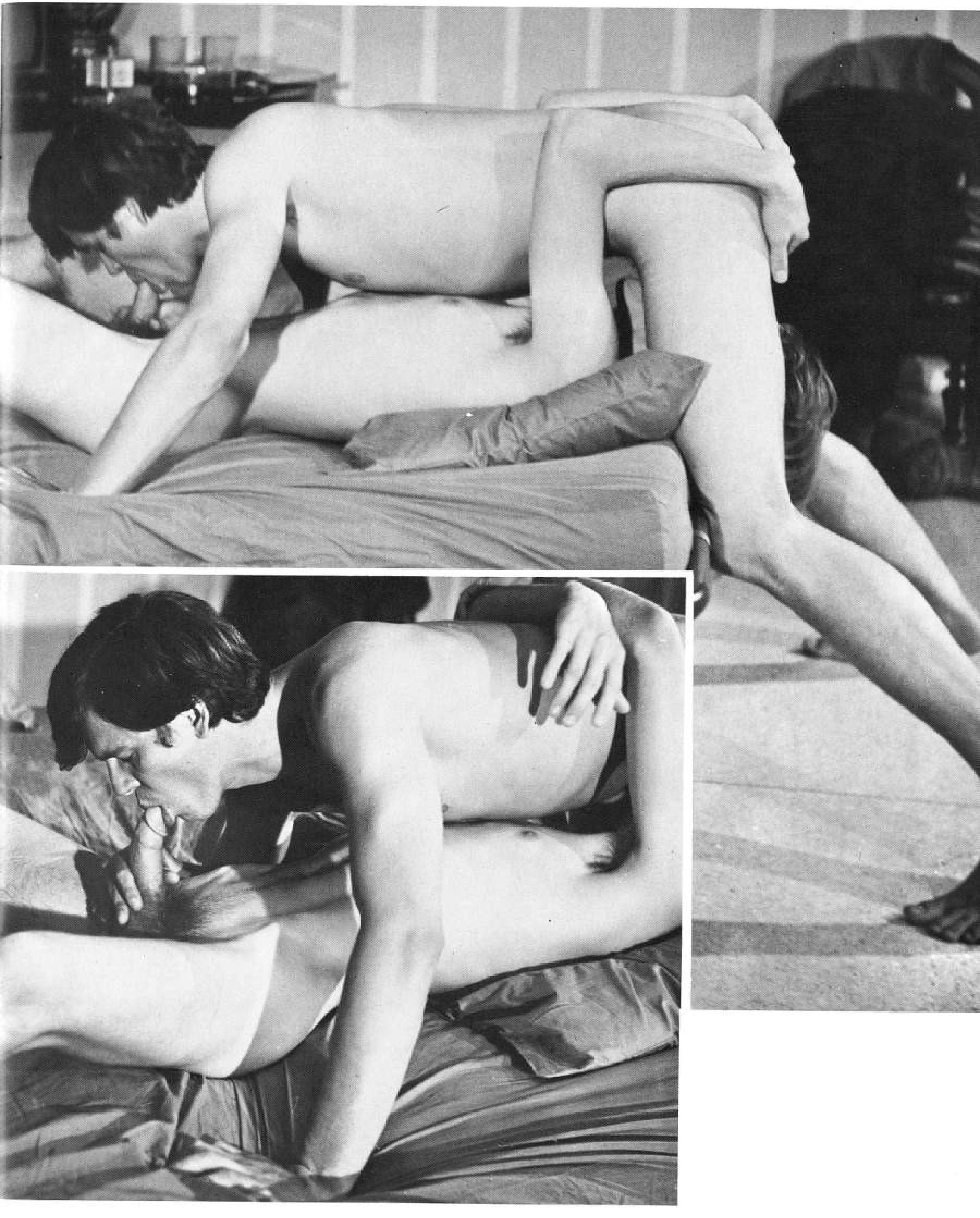
In this face-to-face position either the dominant male or the recumbent male can position the glans in preparation for rectal insertion. In either case the insertion should be slow and should be done with painstaking care. The recumbent male will find that by lying on his back with his legs pulled up and spread slightly apart that the cleft of his buttocks as well as the lips of his anus are automatically stretched slightly apart, which is most beneficial for accomplishing anal penetration easily and smoothly.

Insofar as the dominant male is concerned, he should kneel between the legs of the recumbent partner prior to the recumbent male pulling his knees

up under his chin. When the recumbent male raises up, the dominant male should crouch over him, fitting the penis against the opening of the recumbent male's rectum. Initial penetration in this position can be managed by the recumbent male rather than by the dominant male, although if the recumbent male is unexperienced in the act of penile-anal penetration the dominant male should assume the initiative and be responsible for introducing the penis into the anus by exerting pressure on the penile shaft by pushing forward with his hips.

Once the glans has slipped between the lips of the anal opening the dominant partner should hesitate for a moment, allowing the recumbent male to accustom himself to the intrusion. The act should not continue until the recumbent male has given his permission to do so.

After the penis has been engulfed, the dominant partner proceeds to move his hips in a forward-backward motion, causing the penile shaft to slip in and out of the rectal channel. At no time should the glans be completely removed from the anus; removal of the glans would cause a discomforting delay.



In the face-to-face position, if the recumbent male is desirous of very deep penetration, the dominant male can grasp the ankles of the recumbent male and hold his legs up in the air, spreading them in a v-shape, all the while continuing to move back and forth against the buttocks.

It has been found that some dominant partners, with practice, are able to fellate the recumbent male during anal intercourse while in this face-to-face position. Although this is somewhat difficult to achieve, it is, nevertheless, not an impossible feat. This "grand play" as many homosexuals call this act requires that both partners have above average in length penises; it also is necessary that the dominant partner be supple.

The foregoing instructions on sexual positions and those listed hereafter should be studied by the homosexual without fear of dehumanization or mechanization of sex. To quote Dr. Albert Ellis: "It is claimed that do-it-yourself books lead to the dehumanization and mechanization of sex because of their emphasis on technique. Nonsense! No one seems to become a 'mechanized' swimmer or golfer or a 'dehumanized' cook because he learned the rudiments of swimming, golfing or cooking. Why, then, should improved sexual techniques interfere with humanism?

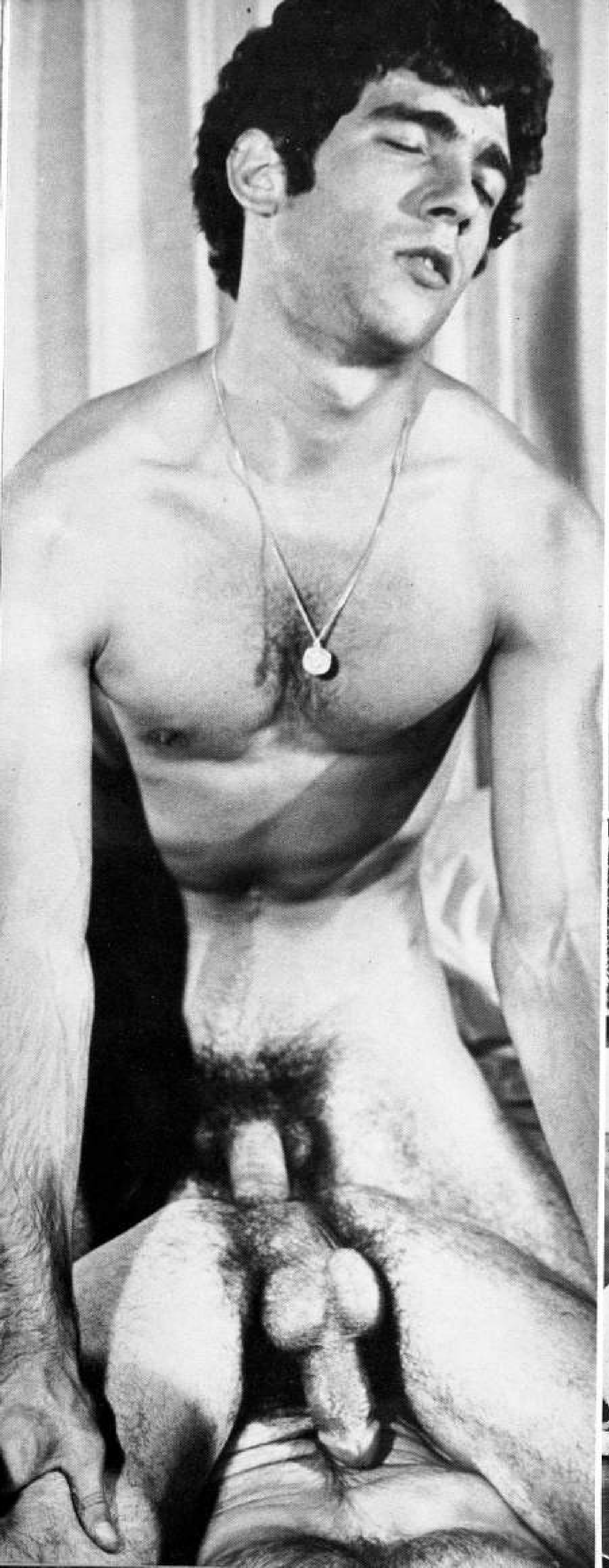
In all positions assumed for accomplishing anal intercourse, it is natural to the homosexual that masturbatory practices be included. Ordinarily, the

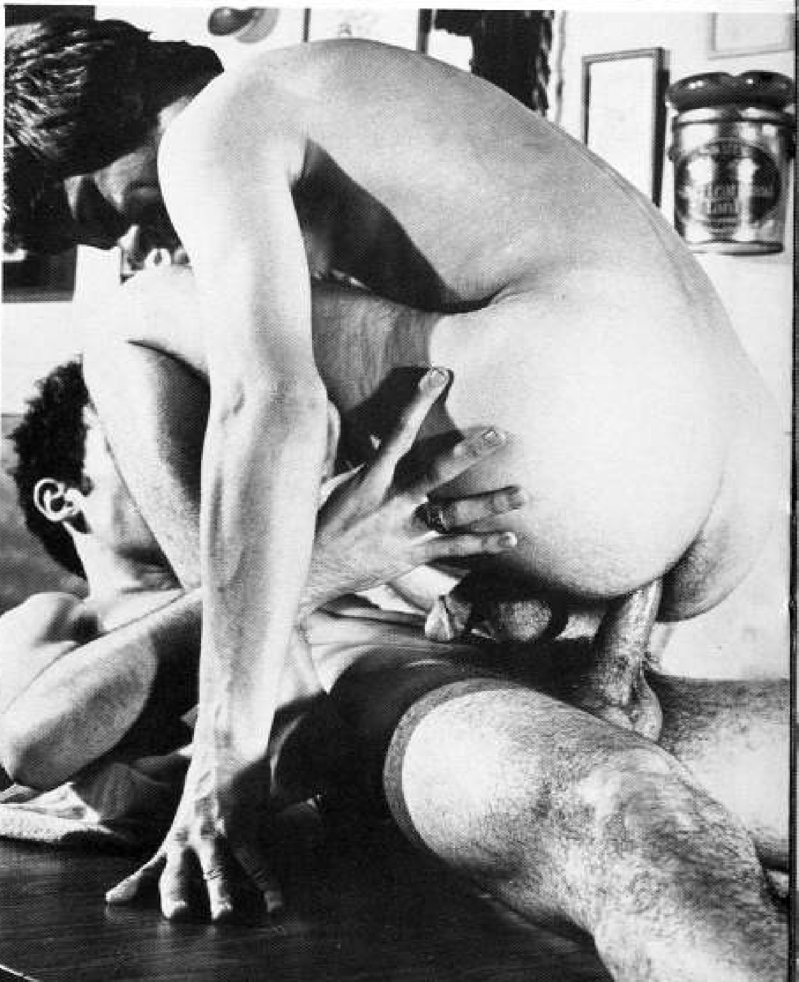
passive partner will not experience orgasm strictly from anal penetration. He might want to masturbate himself during the act or prefer being masturbated by his partner. It is for this reason that adjustments should be made in all basic positions so that access is had to the penis of the passive partner. That is why the basic front-to-back position, practiced with the partners reclining on their sides, is a very popular attitude among practicing homosexuals.

For broader comprehension, we have included a list of variations that may be worked off the front-to-back and face-to-face positions.

SITTING POSITIONS

(1) The inserter lies flat on his back with his legs spread apart. The passive partner or insertee becomes the active partner by sitting astride the inserter, facing him, with his legs drawn up under him in a kneeling position. The insertee takes the inserter's penis in his hand and positions it against the opening of his anal cavity and lowers himself slowly onto the penis until it has fully penetrated the anus. After penetration has been accomplished the seated partner should move up and down on the penis, at the same time rotate his hips very slightly, and the recumbent male should push up and down, matching his movements to those of the partner seated atop him.





(2) A modification of the foregoing position could be made by the seated partner turning to face the feet of the recumbent partner.

(3) The basic seated position can be varied further by having the inserter seated in a chair or on a stool with the insertee positioned on his lap.

(4) An uncomfortable position for some is wherein the passive partner lies flat on his stomach with the active partner sitting astride him, facing the passive partner's feet (back-to-back, so to speak). The active partner raises himself up and leans forward, positioning his penis against the opening of the anus. Then he lowers himself, his face and head resting at the passive partner's feet, and allows his penis to push itself into the passive partner's rectum. This position is used by some male homosexuals who possess a penis with an unfortunate curve or bend to it, or if the opening of the anus is extremely large.

(5) Another seated position worthy of mention, although difficult to manage, is wherein the active partner and the passive partner sit facing each other. The passive partner places his thighs over the thighs of the active partner and moves into the active partner's lap. He raises himself up slightly so that the penis of the active partner can be fitted into the rectum.

STANDING POSITIONS

(1) Both partners stand with the active partner at the back of the passive partner. The passive partner should lean forward, at the same time spreading the cheeks of his buttocks so the opening of the anus is revealed. The active partner should insert the glans into the rectum and press forward slowly and gently until full penetration is achieved. The active partner should then enfold the passive partner in his arms while moving his hips in a forward-backward motion.

(2) The passive partner can lie on his back on a waist-high table or other type support, bracing his feet against the chest and/or shoulders of the active partner standing on the floor facing him. Insertion of the penis into the anus can easily be accomplished in this position.

(3) The passive partner should kneel on his hands and knees at the edge of a bed or bench with his thighs slightly apart. The active partner should stand facing the passive partner, he then should insert his penis into his partner's rectum.

(4) If the active partner is particularly strong, he can assume a standing position while holding the passive partner, whose legs would be entwined around the active partner's waist and his arms around the active partner's neck. Movement in this position, however, is rather difficult to manage.

(5) The "wheelbarrow" position is assumed by the active partner standing between the spread legs of the

passive partner. The active partner reaches down and grabs up the legs, lifting them up to the height of his crotch area. He then holds the legs apart and moves his hips forward until the penile column is directly in line with his anal opening. The active partner pushes inward and entry is thereby accomplished.

The positions outlined heretofore are but a few of the basic positions which are considered as the most acceptable for accomplishing anal intercourse. It should be remembered that there are, of course, other positions which might be tried and participants should not be afraid to deviate from what might be considered the normal positions. Further, it should be noted that positions vary with the individuals involved. If, for example, one partner is extremely tall and the other quite short, naturally adjustments will have to be taken into consideration.

Also, it is important to remember that the words "passive" and "active" used herein are not to be taken in their true literary senses. A passive partner must also be active, as an active partner must be passive. This may seem somewhat paradoxical, but there should never be a completely passive partner in any affair as this reduces the affair to simple one-sidedness.

In conclusion, it must be stressed that any procedure indulged in must not violate the tastes or feelings of either partner.

ORALISM: THE ORAL EROTIC

We have already dealt with two of the three main homosexual activities, masturbation and anal-genital relations, therefore we will now proceed to the third main sexual activity, that of oralism.

While anality is generally confined to the act of penile-anal insertion, orality covers a much wider range of possibilities.

Kisses require little definition. For the oral erotic, however, the range is again wide. Mouth-to-mouth kissing may range from the simple touching of the lips to the so-called soul kiss, which Kinsey defines as follows: "It may involve tongue-to-tongue contacts, lip and tongue sucking, tongue contacts with the inner mouth, with the inner surfaces of the lips and teeth, deep explorations of a partner's mouth, contacts with the inner surfaces while nipping and gentle biting of the tongue. . .because of the nerve endings on the lips and tongue stimulation in this area may be very effective and orgasm occasionally results from such deep kissing."

The erotic kiss, at least the longer and more fervent erotic kisses between lovers, are essentially, and in contrast to the formal, conventional kiss, not dry but moist. The moisture passes from each mouth to the other, even in a very small amount.

In addition to mouth kissing, of course, the mouth may be applied to almost any part of the body. Application of the mouth to the anus, involving contact, kissing, sucking or tonguing, is called analingus. Analingus is rarely a means of sexual gratification in itself, but most often occurs in conjunction with other activities, as a means of increasing sexual arousal, as a prelude to anal insertion, and as an accompaniment to fellation.

Podolingus, the licking or sucking of toes and feet, is also encountered among homosexuals. Sucking of the toes is referred to as "shrimping."

The so-called body kiss consists of kissing and tonguing of nearly the entire body surface, including breasts, throat, armpits, anus, genitals, feet, etc. This is sometimes referred to as "around the world."

There is some question as to whether the navel is an erogenous zone. Koble and Warren state that "no

one has a definite answer to this question. It is probably, considering that it is utilized as the object of oral fondling, more of a psychological than physiological erogenous zone."

Love bites can be applied to any part of the body. It breaks no skin as a rule and draws no blood, but there is no denying that the love bite does involve certain sadistic overtones. However, when the body is sexually stimulated, it appears to filter out the pain and leave a pleasurable sensation in the mind.

When one thinks of oral sexual activities between homosexuals, one thinks most often of mouth-genital contact, i.e., fellation and irrumation. These two terms somewhat overlap and are often used confusingly. In general, to fellate is to apply one's mouth to the penis of another; to irrumate is the reverse, to insert one's penis into another's mouth.

Legman, although in a heterosexual context, suggests that the difference between fellation and irrumation rests with position, and his remarks are probably applicable to homosexual contacts as well: "In fellation the man is passive and the fellatrix is active. The man is usually lying on his back while the fellatrix lies or crouches over him, or kneels before him, holding and directing the man's genitals with her hands at first, or seizing him by the buttocks to force him deeper into her mouth. In irrumation, the man (the irrumator) is active and the female passive. The man almost always stands, half kneels or lies face down over the supine or kneeling female, whose face and body he purposefully dominates in a virile way."

There is a reasonable agreement among psychiatrists, psychologists, and others that the male goes through a homosexual stage in his early growth which, in the case of the heterosexual, he outgrows, while the homosexual remains arrested there.

Dr. Ernest M. Poate refers to a period of conscious homosexuality through which nearly every boy passes at about the age of puberty. Often this phase takes the form merely of anal and oral fantasies. This is at variance with other opinions which hold that the young male is only seeking a substitute for the female. Englinton, too, feels that the young man in this phase may be acting upon an actual and conscious desire for a specific form of sexual gratification or activity.

As the boy advances into his teens, it is supposed that his sexual interests gravitate toward genital intercourse. This is not always the case, however, not even with heterosexuals who frequently retain their

interest in oral activity.

This leaves unexplained, too, the so-called bisexual male, who may marry, father children, and fully enjoy heterosexual, genital intercourse, yet may also enjoy homosexual activities. It is gratuitous to suggest that this is the result of a jaded and generally uninhibited appetite; in many instances, there is a distinct pattern of preference, oral activities being welcomed, for instance, while other homosexual activities, such as anal insertion, being shunned.

It has been suggested that the initial sexual experience may dominate in later preference. J. R. Parke, among others, supports this view. This would seem especially applicable where the boy involved was at an impressionable age when the experience occurred.

Freud has a great deal to say regarding oral and anal fixation, suggesting that the child goes through distinct stages, beginning with the oral stage, before reaching a stage of genital primacy. Certainly we can see that these stages have a continuing influence. Homosexual or heterosexual, nearly every individual derives pleasure from certain acts of orality such as kissing. Bergler tends to agree with Freud, and theorizes that the adult homosexual has never fully recovered from the weaning process.

However, not all authorities agree with this theory. Donald J West insists that not all homosexuals can be described as orally or anally fixated. If we are to explain homosexuality, after all, in terms of such fixation, that fixation must be discernible in every case of homosexuality. If the law of gravity is to explain the falling of an apple from a tree, it must cover every apple; the law fails when just one apple floats upward.

There is a physiologic side, part of which is apparent from our previous discussion of the sexual anatomy of the male. If we reduce things to their simplest form, we can see that nearly every form of sexual gratification is the same in its essence; friction of the penis through erection, to climax and, if age and health permit, ejaculation. It may be that we are stepping through the looking glass when we seek the motives which lead one to enjoy oral intercourse, for example, when what we ought to question is the inhibition that prevents other individuals from enjoying the act. It may be that oral intercourse is natural to the human animal, as it is to other mammals, and a distaste for such acts unnatural.

This is not to deny that there are differences between various forms of sexuality. The vagina is not the anus, the anus is not the mouth, the mouth is not the hand. The penis, however, does remain the penis. There is a wider gap between coition and masturbation than there is between coition and fellation. It is mere foolishness to suggest that the male who can enjoy both of the first two cannot physiologically enjoy the latter. Too many authorities, self-styled and others, have devoted much effort to finding differences between these activities. The differences between the pleasure derived from one sexual act and another are, excepting certain instances of physical abnormality, probably psychological.

It might be noted that in other forms of homosexual activity, such as masturbation and anal intercourse, the acts performed more or less parallel heterosexual or solitary activities, and may create less of a psychological hardship for the individual. But oral intercourse is another matter; there is a sure homosexual stigma attached to it.

The roles of the two individuals are quite different, and even if we can agree with Magnus Hirschfield, that oral intercourse is comparable to masturbation, we must realize that this applies only to the role of the irrumator, and not to the fellator. Moreover, in many relationships the partners tend to remain fixed in one role or the other, either active or passive.

With the exception of masturbation, which may be only an adjunct to other activities, fellation is certainly the most widespread homosexual activity. For the irrumator, or inserter, the experience is not much different from vaginal intercourse with a woman skilled in the use of vaginal muscles. Homosexuals and bisexuals fond of irrumation are quick to stress that not all women are so skilled.

We find ourselves again faced with the objections that non-participants in oral activites post. They are probably largely a matter of social conditioning. We find that in other societies where the social climate is different, males grow to manhood quite uninhibited regarding fellation. In our own culture, guilt, the fear of losing one's masculinity, is probably as important a factor as any in determining whether a particular male will or will not engage in oral activity.

ORAL-GENITAL TECHNIQUES

In order to perfect acts of oral sex it is advisable that one become familiar with the various erogenous

zones of the male anatomy. These have been fully outlined in Volume I and should be studied carefully. The degrees of sensitivity of the various zones vary from individual to individual so it is advisable that the participants familiarize themselves with one another so that the greatest pleasure might be realized from the act.

Oragenital sex should be an extension or continuation of mouth-to-mouth kissing. The aggressor should move from the mouth, concentrating at first on various parts of the face and head, gradually working his way downward to the chest, nipples, navel, abdomen, genitals, etc. There is, of course, a right way and a wrong way to do anything and everything. The wrong way would be to produce discomfort, even pain, in the performance of oragenital sex. As for the right way, here are a few techniques of homosexual fellation:

(1) The fellator should be careful to protect the shaft of the penis from being scraped by his teeth. This is easily accomplished by opening wide the mouth and drawing the upper and lower lips over the teeth. By doing this the lips act as a buffer and will protect the penile shaft from abrasions.

(2) The fellator can grip the penile column with one hand, holding it upward away from the abdomen. The hand holding the penis can be positioned anywhere along the length of the shaft; the hand will act as a stopper, so to speak. For deep penetration the hand should be at the extreme base of the column; for shallow penetration it should be closer to the glans. (Note: Experienced fellators sometimes dislike holding the shaft at all and can regulate the degree of penetration without their hands acting as a guide.)

(3) Moisten the lips and the glans or head of the penis. The mouth should be permitted to secrete an ample supply of saliva with which to coat the penile shaft. It is almost impossible to perform fellation to any degree of satisfaction when the mouth is dry.

(4) Take the glans between the lips and begin a gentle sucking action, at the same time flicking the tongue over and around the glans. It is usually advisable to allow saliva to drip from between the lips, wetting the shaft thoroughly.

(5) Gradually slide the penis into the mouth, all the while working on the glans and shaft with the tongue, being careful to keep up a gentle sucking action all the time.

(6) The shaft of the penis should be sucked into the mouth until the glans connects with the opening

of the throat. Care should be taken that the person being fellated does not force himself deeper into the mouth than the fellator will permit, or can accommodate. The depth of penetration should be decided by the fellator. Breathing, naturally, is of prime concern, and the blocking of the breath by the penile column will cause gagging and/or choking. Some very accomplished fellators can, by turning their heads at various angles, accommodate the entire penile shaft, but this should not be attempted until the basic oragenital technique has been perfected.

(7) While maintaining a constant sucking action on the penis, the fellator should move his head toward and away from the irrumator, sliding the penis in and out of the mouth, at the same time working the tongue over the glans and around the shaft.

(8) The pressure of the sucking action should be increased as the act progresses. Further, the tempo of comfortable and allow the irrumator to ejaculate deep into the mouth. If he can, the fellator should the head motions should also be increased as the orgasmic phase approaches.

(9) While fellating the irrumator, the active partner should not hesitate to allow his hands to roam over his partner's body. The testicles should be cupped and toyed with; the hands should smoothe and caress the thighs, the legs and buttocks. It is advisable, if the partners have no objection thereto, to penetrate the anus with the fingers during fellation.

(10) The fellator can usually tell when the irrumator is ready to climax. At this point the irrumator should not allow his emotions or passions to become too unrestrained. It is very possible to gag or cause discomfort to the fellator if the penile shaft is moved too forcibly into the fellator's mouth and throat. For this reason, caution should be exercised, particularly during the orgasmic phase of the act.

(11) At the time of orgasm the fellator should draw the penis as far into the mouth or throat as is

swallow the semen. Not to do so amounts to a rejection of the partner.

(12) The fellator should not remove the penile shaft from the mouth until the orgasmic phase is completed. The irrumator's glans is extremely sensitive usually after ejaculation and the oral caresses of the fellator thereon can be most uncomfortable. It is for this reason that the fellator should not concentrate upon orally manipulating or caressing the glans after the climax has been reached by the irrumator.

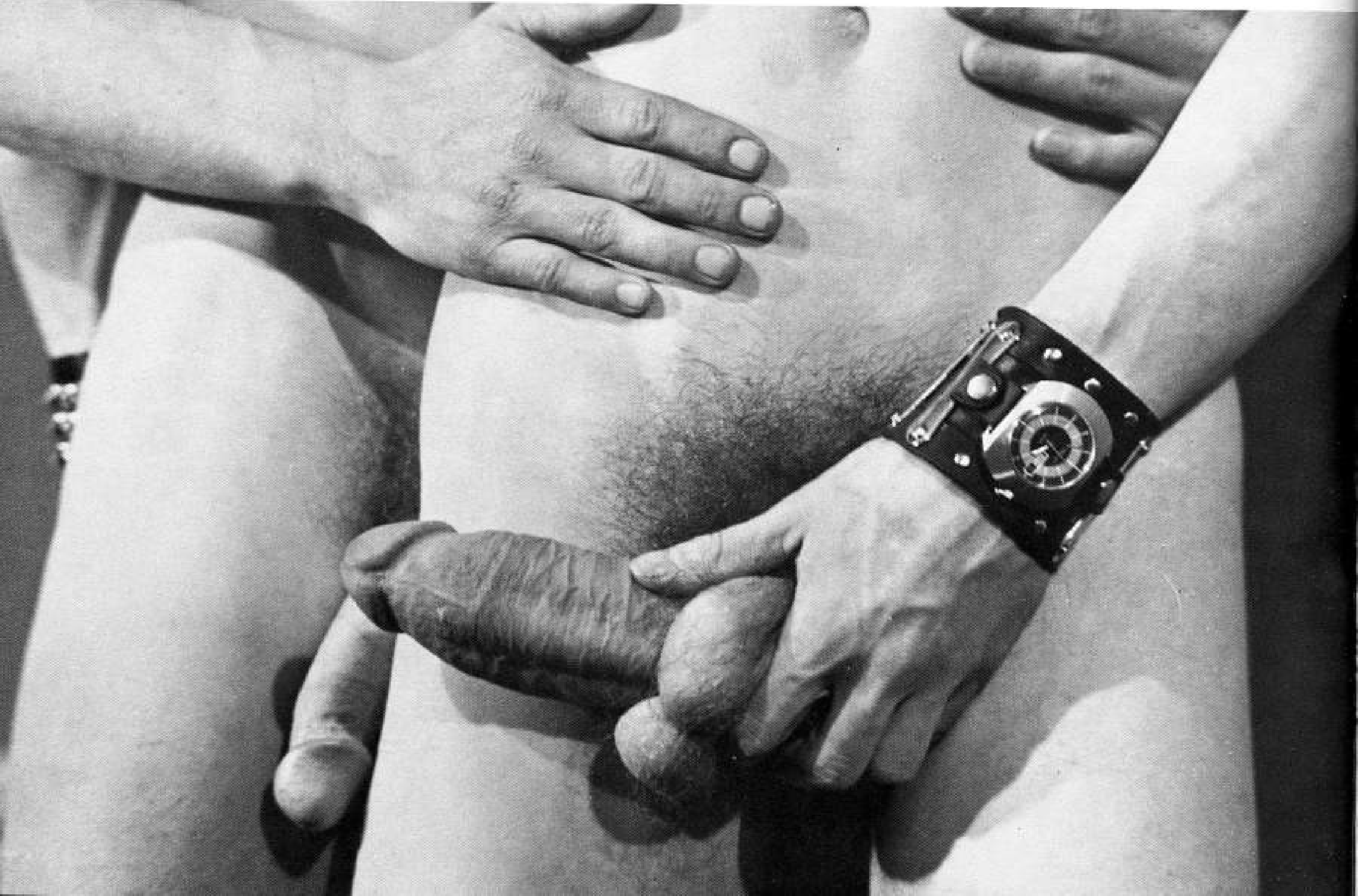
By mastering the art of fellation the fellator can easily build the act from one plateau of excitement to another. It is advised that the penis not be attacked directly by the fellator. He should concentrate upon other erogenous zones—the thighs, abdomen, testicles, navel, anus, gradually working to the shaft and head of the penis.

If very accomplished in the art of fellation, the fellator can draw the penis of his partner into his mouth and throat and move on it with the greatest of skill. With practice, one can pull the shaft of the penis entirely into the mouth, regardless of the length thereof. This is all a matter of relaxing the throat properly and regulating one's breathing rhythm. However, this advanced form of fellation should not be attempted except by one very adept in the art of oragenital sex practices.

ORAL-GENITAL CONTACT: RECLINING POSITIONS

(1) The irrumator lies flat on his back, legs spread apart, with the fellator kneeling between his legs. In this position the fellator can either masturbate himself while fellating the irrumator, or, after the irrumator has experienced his orgasm, the partners can reverse roles.

(2) One partner lies flat on his back with legs spread; the other male kneels over him in a head-to-toe position. This is commonly known as the classic "sixty-nine" position. The penis of the one is centered under the mouth of the dominant partner; his penis is centered over the mouth of the recumbent partner. This position is highly favored by homosex-



uals as well as by heterosexual couples.

(3) A variation of the sixty-nine position is made when the partners assume a head-to-toe position while reclining on their sides.

(4) The fellator lies on his back. The irrumator kneels over his chest and leans forward, placing the penile shaft into the mouth of the recumbent partner.

(5) A rather unusual position, yet one that seems to hold popularity with homosexuals, is for the irrumator to lie flat on his stomach with the shaft of his erect penis pushed down between his legs. The fellator crouches between the legs of the irrumator and fellates him from the rear. Oral-anality can be practiced in this position as well.

SITTING POSITIONS

(1) The irrumator sits on the edge of a bed or on a chair or bench; the fellator kneels on the floor between his legs, placing his face in the irrumator's lap.

(2) The irrumator sits up in bed and spreads his

legs wide. The fellator lies on his stomach stretched out between the legs of his partner. The fellator positions his mouth on the genitals of the irrumator.

(3) The irrumator sits with his knees drawn up. The fellator lies on his side under one leg of his partner and performs fellation.

(3) There are instances wherein the fellator, being particularly strong, stands erect, places his hands on the waist of his partner and lifts the partner up until the genitalia is level with the mouth of the fellator.

(4) The irrumator stands on a table or other high support; the fellator stands on the floor in front of him—his face even with the irrumator's genital area.

ORAL-ANAL CONTACT

Oral-anal contact is termed analingus and refers to mouth anus contact. Few homosexuals interviewed did not admit to the practice, either actively or passively.

(4) The fellator stretches out full length on his back. The irrumator sits on his chest, facing the fellator. The irrumator pushes down on the shaft of his penis and directs it into the mouth of his fellator.

(5) The fellator assumes a sitting position on the bed. The irrumator, facing him, drapes his legs over the fellator's shoulders and sits atop the seated fellator, balancing his weight on the fellator's body.

STANDING POSITIONS

(1) The irrumator stands erect. The fellator kneels or sits before him, with his mouth level with the penile shaft.

(2) If the partners are very agile and muscular, one might assume a handstand before the other (advisably propped up against a wall or some other form of support) while the other partner stands against his front. This is the standing version of the sixty-nine.

Chicago

What makes analingus attractive to the homosexual? Just as each individual goes through a stage of orality, so does he pass through a stage of anality in which his pleasure centers itself on the anus. Some people probably remain fixated in these areas, and even when this is not the case, these early sensations leave their imprint upon our adult tendencies. It would probably be more surprising if an individual did not experience some anal pleasantries, however unrecognized.

ORAL-ANAL TECHNIQUES

The basic technique in performing anal-oral contact is simple enough to outline. It is advisable that during the evolution stage the partners assume the head-to-toe reclining position (the sixty-nine position) so that each may be cognizant of the other's reactions to the act.

(1) The lips and tongue should caress the thighs, penis, scrotum—the general pubic area.

(2) The recumbent partner should slowly ease himself upward, licking the scrotum and perineum. His hands should be placed on the dominant partner's buttocks. Using his thumbs, the cheeks of the buttocks should be parted gently and the recumbent partner should ease himself up until his mouth and tongue touch the anal opening.

(3) The tongue should tickle and lick the lips of the anus, penetrating with tiny circular motions. The tongue should be stiffened and darted in between the lips of the anus, penetrating as far as possible. Those expert in this practice are capable of fitting a goodly portion of the tongue into the rectum, but these individuals are in the minority.

(4) The partners should keep the cheeks of the buttocks spread as far apart as possible. This pulls the lips of the anus slightly apart, exposing the more sensitive regions of the inner part of the opening.

(5) Long, lapping strokes should be administered to the anal opening from time to time and the buttocks should be kissed and caressed. Some partners find sexual stimulation in being bitten gently and nibbling at the anus.

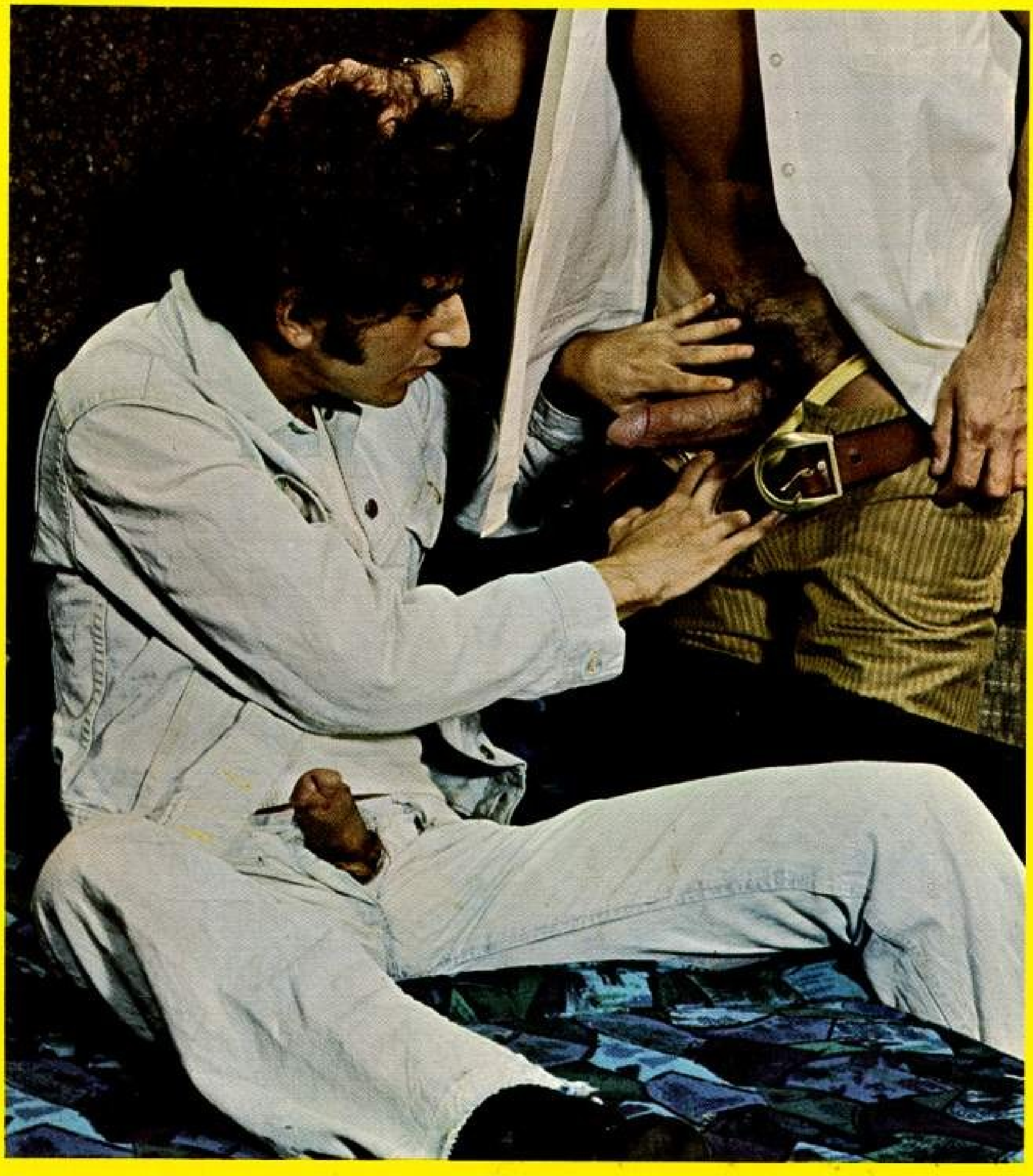
ORAL-ANAL POSITIONS

(1) One partner lies on his stomach with his legs spread apart. The active partner kneels between his legs, bending his head down toward the buttocks.

(2) One partner reclines on his back with his legs up in the air. The other partner sits astride the recumbent partner's head, kneeling slightly forward to support some of his own body weight. The dominant partner fits his arms around the legs of the recumbent partner and pulls them toward him, causing the recumbent partner to bend at the waist, elevating his buttocks.

Naturally the foregoing is not a complete listing of the numerous ways in which the mouth plays a part in one's sexual life. There are many unusual practices, some of them exceedingly rare. It would take volumes to encompass all of them. Nevertheless, no one should say whether an individual should or should not practice oral love. It is the individual himself who must make the decision.

GAY SEX TECHNIQUES



AN INFORMATATIVE SEX MANUAL

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